Maternal and Child Health Services
Title V Block Grant

State Narrative for Iowa

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are provided as an attachment to this section.
An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input was conducted in several different venues this year. A comprehensive method of public input was used for the Title V needs assessment. Stakeholders throughout the state were involved at three different levels. See the needs assessment section for more information. The needs assessment, state priorities, and proposed state performance measures with activities were posted via the Iowa Department of Public Health Web site.

The Bureau of Family Health Grantee Committee is comprised of representatives from all 34 local MCH and Family Planning contract agencies. Local contract agencies are encouraged to provide input and influence bureau-related policy and quality assurance activities. Input from the committee was used to determine the Title V priority needs and performance measures.

There were about 150 hits to the IDPH Web site during the period of public input for the 2011 National and State Performance Measures. There were another 100 hits to the Public Input page for the period comment period for the needs assessment. Emails from local community partners provided input on the state priorities, performance measures, and activities within the performance measures. This input was reviewed and incorporated in to the application. Several comments pertained to the new state performance measures and the use of the Title V index.

The Iowa Maternal and Child Health Advisory Council also provided public comment via the IDPH Web site for the needs assessment and the state performance measures. The Council members represent a wide spectrum of providers, consumers, parents, and policy makers that are concerned about MCH issues. This input was provided prior to their June 16, 2010 meeting, and the council endorsed the state plan subsequent to that meeting via electronic vote.

Local MCH contract agencies provided input on the needs assessment, Title V priorities and the performance measures. See "Iowa 2015" for a complete description.
An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Iowa Department of Public Health (IDPH) Bureau of Family Health (BFH) and the Child Health Specialty Clinics (CHSC) embarked on the 5 year needs assessment (NA), March 2008. Key staff from IDPH BFH and Oral Health and the University of Iowa CHSC provided leadership for the process. Coordinators used the framework included in the Title V Application Guidance to ensure that all steps in the NA were addressed. The process was guided by the Iowa MCH 2015 Logic Model which outlined four phases: Phase 1-Problem Identification, Phase 2-Priorities, Phase 3-Plans, and Phase 4-Performance.

Resources: Building strong partnerships for the NA went far beyond the three pivotal agencies. During the 2-year process the Iowa MCH2015 coordinators maintained close contact with key state and local MCH stakeholders, including families. Iowa MCH2015 received input from individual families and organizations of family advocates. Parents of children and youth with special health care needs, including the Parent Consultant Network, played a vital role in the 5 year NA. An extensive range of data resources contributed to a thorough assessment.

Iowa MCH stakeholders carefully considered why each new priority should be added to the state's Title V plan for the upcoming 5 year period. Data detail sheets were prepared for each identified need. The end result was a replacement of the 2005 SPMs for the new SPMs which will be addressed beginning in 2011. The prioritization method chosen replicated that used in the previous two cycles. The method was adapted from materials included in the Family Health Outcomes Project at the University of California San Francisco. Based on the extensive investigation of existing and emerging needs and the results of the broad based stakeholder prioritization process eight priority needs were selected for the 2011-2015 project period. Priority needs and corresponding performance measures are as follows:

Problem Statement--Lack of adoption of quality improvement methods within maternal and child health
SPM #1: The degree to which the state MCH Title V program improves the system of care for mothers and children in Iowa

Problem Statement--The degree to which components of a coordinated statewide system of care for CYSHCN are implemented
SPM #2: The degree to which components of a coordinated statewide system of care for CYSHCN are implemented

Problem Statement--Racial disparities in maternal and child health outcomes.
SPM #3: The degree to which Iowa's state MCH Title V program addresses health equity in MCH programs

Problem Statement-- Lack of coordinated systems of care for preconception and interconception care for high risk and low income
SPM #4: Percent of family planning clients (women and men) who are counseled about developing a reproductive life plan

Problem Statement-- Barriers to access to health care, mental health care and dental care for low income

SPM #5: The degree to which the health care system implements evidence based prenatal and perinatal care

Problem Statement-- Lack of access to preventive and restorative dental care for low income pregnant women
SPM #6: Percent of Medicaid enrolled women receiving preventive dental health services during pregnancy

Problem Statement-- Lack of providers to do restorative dental treatment for children age 5 years and younger
New SPM #7: Percent of Medicaid enrolled children 0-5 who receive a dental service

Problem Statement-- High proportion of children age 14 years and under experiencing unintentional injuries.
SPM #8: Rate of hospitalizations due to unintentional injuries among children ages 0-14
The eight new state performance measures will be evaluated each year by either process indicators or outcome indicators.

Progress on priority needs from the previous 5 year period was considered as part of the prioritization process. Those priorities formed the core of the problem list considered in the current NA. Priorities needs that were not incorporated into the current list of priorities were determined to be addressed with sustainable programming developed over the last five years.

Changes in Population Strengths and Needs since Last 5-year Needs Assessment Data detail sheets provided snapshots of the population changes since the last NA. Recognized needs not previously addressed, although likely present and not recognized, include the following: preconception and interconception care, oral health care access, systems for monitoring the impact of social determinants of health, and risk for injury.

Capacity to Address Priority Needs The NA process included extensive review of Iowa‘s MCH program capacity to address the newly selected priorities. In the past 5 years Iowa has made substantial progress in establishing an early childhood system responsive to the needs of growing families. In addition, program development in the areas of medical home, developmental screening, preventive oral health services, and mental health screening and treatment services added significantly to addressing previously noted unmet needs.
Resource data in conjunction with informed opinion from content experts resulted in ambitious but realistic goal setting designed to advance development of Iowa's MCH system. Iowa is well equipped to address the state priority needs. Through the local Title V and Title X contractors, other state agencies as well as statewide partnerships, Iowa‘s MCH program is able to provide direct care services, enabling services, population based services, and infrastructure building to it's MCH population.

III. State Overview

A. Overview

Key factors that provide context for the state's Maternal and Child Health (MCH) annual report and state plan are highlighted in this overview. This section briefly outlines Iowa's demography, population changes, economic indicators and significant public initiatives. Additionally, major strategic planning efforts affecting development of program activities are identified.

Iowa's Land

Most of Iowa is composed of gentle rolling prairies, covered with some of the world's most fertile soil and lies between the high bluffs of the Mississippi and Missouri Rivers. Iowa is one of the country's most important and prosperous agriculture states and is known as the breadbasket of the country. The deep black soil yields huge quantities of corn, soybeans, oats, hay, wheat and barley, which help support its cattle and hogs and supplies the large food processing industry. Manufacturing, especially agribusiness, is a large source of income for Iowans.

Changes in Demography

Iowa is a rural state with approximately 2.9 million people. According to census projections, Iowa will experience a modest three percent growth in population by 2015. The population will continue to shift from rural areas to urban areas. One-third of Iowa's 99 counties are expected to lose population.

Ninety-four percent of the population is white; however, racial and cultural diversity is increasing. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000, and continued to increase to 4.2 percent in the 2008 estimate. Birth data confirms this increase. In 2000, live births to Hispanic women made up 5.6 percent of all births, double the population proportion in the same year. This ratio continues in 2008 (8.2 percent vs. 4.2 percent). Approximately 240,041 children are ages five and under and make up about 8.0 percent of the total population. Of the children between the ages of 0 - 5, 8.9 percent are children of Hispanic origin. There are an additional estimated 8.9 percent of children who have a special health care need. Children ages 19 and under had a higher rate of poverty (22.3 percent) than the general population (16.5 percent) in 2007.

Iowa's overall population increased by 2.6 percent from 2000 to 2009. The U.S. Census Bureau, 2008 American Community Survey shows that the percentage of population Hispanic and/or Non-white is 17 percent in children ages 0 to 4, 15 percent in children ages 5 to 17, nine percent in 18-64 and three percent among 65 and older.

Even with the influx of new citizens, Iowa's total population is projected to experience only modest growth between now and 2015. While the overall population remains stable, the minority populations are expected to grow in both absolute numbers and total population.

Other key demographic data that paint the picture of Iowa includes 32 percent of families are single parent families, 13.3 percent of poor families have children, 17 percent of adults are without a high school diploma and only 67 percent of 4th graders demonstrate reading at a proficient level.

Employment and Population Changes

Iowa's unemployment rate has steadily increased since 2000. Iowa's seasonally adjusted unemployment rate was 6.8 percent in May 2010, one percentage point higher than May 2009 rate of 5.8 percent. The statewide estimate of unemployed workers dropped to 115,400 in May 2010 from 116,400 in April 2010. The number of unemployed persons stood at 96,200 a year ago.

The total number of working Iowans was 1,571,600 in May 2010 down from year ago when it was

1,575,000.

Poverty
The 2008 data showed a decrease in the number of Iowa families living in poverty from 7.3 percent in 2006 to 6.1 percent in 2008. This is approximately 50,000 families defined as poor by the federal poverty level. There were 13.3 percent Iowa families with children ages 0 to 17 living at or below the federal poverty level in 2007.

Over the past year Iowa has engaged in focused strategic planning at the state and local level with public and private stakeholders. Title V administration used the program level strategic plans to help determine Title V priorities. A high level overview is provided below.
Focused Strategic Plan: Early Childhood System development
Community Empowerment was created through legislation in 1998. The purposes of the legislation was to establish local community collaborations, create a partnership between communities and state government and improve the well-being of children 0 to 5 years of age and their families. Community Empowerment areas were designated to cover all 99 counties directly influencing community-based MCH services in Iowa.

The Early Childhood Comprehensive System initiative, Early Childhood Iowa (ECI), was established in 2003. ECI partners with the Iowa Department of Management Office of Empowerment at the state and local level to improve and enhance the early childhood system including coordination and integration. The ECI Council of stakeholders and six component workgroups developed and implemented various aspects of the early childhood system. ECI also focuses on building public and private stakeholder partnerships and relationships. After several years of working with policy makers, state departments and early childhood stakeholders, Early Childhood Iowa was codified in administrative rules in May 2009. The process was completed with input from the ECI Council and the six component groups. The ECI governance structure was placed within the Department of Public Health.

Current economic conditions pushed recent legislative sessions to more thoroughly and intentionally look at efficiencies and accountability in state government. Community Empowerment often became a focal point in conversations during legislative discussions regarding the efficiencies and effectiveness of Community Empowerment, both at a state and local level. In June 2009, the Department of Management - Office of Empowerment hosted a LEAN event to give leaders in early childhood the opportunity to reflect and build on what works in Iowa, while developing new models and strategies based on the latest early childhood research.

A diverse representation of state and local early childhood stakeholders came together for a week long process to identify first steps in improving the effectiveness and efficiency of the Early Childhood system.
Four priority areas were identified and action plans were developed as follows:
1. Levels of Excellence;
2. Regionalization and Re-define Empowerment Areas;
3. State Structure; and
4. Marketing.

Legislation passed in March of 2010 combines the work of Early Childhood Iowa and Community Empowerment and establishes the system building efforts in the Department of Management, effective July 1, 2010. The structure at the local and state level was named Early Childhood Iowa. Department of Management -- Office of Early Childhood leads system level activities in partnership with state agencies and private stakeholders. There will continue to be an Early Childhood Iowa Board, Early Childhood Stakeholder Alliance, six component workgroups and an Early Childhood Technical Assistance Team. While further system development is anticipated as a result of the structural changes, realignment of roles and responsibilities may temporarily delay advancement.

Over the past three years, cultural competency has been a priority for ECI. ECI hosted a diversity symposium and retreat in 2007 and 2008. As a result of these initiatives, a Diversity Workgroup was formed and a workplan was developed. The Diversity workgroup and several ad hoc workgroups were formed to work on specific areas of the workplan and provide direction for addressing cultural competency.

Focused Strategic Plan: Project LAUNCH
Fragmented systems, inadequate resources, lack of understanding and lack of accountability contribute to Iowa's failures to meet the mental health needs of Iowa's youngest citizens and their families. Iowa's Project LAUNCH seeks to develop the necessary infrastructure and system integration to assure that Iowa children are thriving in safe, supportive environments and entering school ready to learn and able to succeed.
Iowa's Project LAUNCH targets children ages zero to eight and their families in a seven-zip code area of inner city Des Moines (50309, 50310, 50311, 50313, 50314, 50315 and 50316) with a focus on low-income and minority populations who are traditionally underserved. The purpose of Iowa LAUNCH is to develop a sustainable, systemic community-approach to promoting social, emotional and behavioral health for young children and their families.
Overall project goals are to:
1) Build state and local infrastructure to increase the capacity and integration of the children's mental health system into a comprehensive early childhood system of care to promote positive development for Polk County children ages zero to eight and their families;
2) Deliver family-centered, fully integrated evidenced-based services for children living in a targeted community at-risk for poor social emotional outcomes, and
3) Promote sustainability and statewide spread of best practices for system development.
A state and local Project LAUNCH Strategic Plan was finalized in May 2010.

Focused Strategic Plan: Project Connect
Project Connect is a two-year violence prevention initiative designed to find new ways to identify, respond to and prevent domestic and sexual violence, as well as, promoting an improved public health response to abuse. It is funded by the Office on Women's Health of the U.S. Department of Health and Human Services in conjunction with the Family Violence Prevention Fund. Selected Project Connect grantees will work with family planning, adolescent health, home visitation, and other maternal child health and perinatal programs to develop policy and public health responses to domestic and sexual violence. Project Connect also supports the creation of continuing medical education materials designed to reach thousands of providers and health professional students. The project will use a Web-based platform to educate and promote clinical skills for medical and nursing students and providers. participants receive continuing education credits while learning to assess, identify and provide support and intervention with victims of violence in a variety of health settings.

Focused Strategic Plan: Public Health Redesign
Public Health Modernization is a joint initiative of the department and local public health providers. Ongoing since 2004 Public Health Modernization has achieved several milestones. The first was in December 2007 when the Iowa Public Health Standards were published after nearly two years of development. The standards were developed in two categories. The first category deals with public health infrastructure and includes criteria in the areas of governance, administration, communication and information technology, workforce, community assessment and planning and evaluation. The second category describes public health services provided including; preventing epidemics and the spread of disease, protecting against environmental hazards, preventing injuries, promoting healthy behaviors and preparing responses to and recovering from public health emergencies.

In 2009 the Public Health Modernization Act was signed into law by the Governor of Iowa. The act called for the formation of a voluntary accreditation program for Iowa's local and state public health departments. Additionally the law called for the formation of two advisory bodies to steer

the Modernization initiative and make recommendations to the state board of health about accreditation and the Iowa Public Health Standards. The Public Health Advisory Council has responsibility for finding an accrediting entity for the state of Iowa, and for the review and revision of the Iowa Public Health Standards. The Public Health Evaluation Committee has responsibility for evaluating the public health system, and the affect of the Iowa Public Health Standards.
In 2010 further laws were passed updating Chapter 136 and 137 of Iowa Code. These sections describe the roles and responsibilities of the state board of health and local boards of health respectively. Both chapters were updated to align with the Public Health Modernization Act and the Iowa Public Health Standards.
Finally, in 2010 Iowa was selected as a Beta test site for the Public Health Accreditation Board's pilot of the national accreditation system. Iowa is one of eight state health departments selected to participate. As part of the process IDPH will not only be preparing for accreditation but will begin implementing quality improvement processes to address gaps in ability to meet the standards, and to improve work that already meets the standards.

Focused Strategic Plan: Local MCH Agencies
Local maternal health and child health programs promote the development of community-based systems of preventive health care for pregnant women, children ages 0 through 21, and their families. Goals of the maternal and child health (MCH programs) are to:
• Promote the health of mothers and children by ensuring access to quality maternal (MH) and child health (CH) preventive health services (including oral health care), especially for low-income families or families with limited availability of health services
• Reduce infant mortality and the incidence of preventable diseases and disabling conditions
• Increase the number of children appropriate immunized against disease.

Local MCH contract agencies are charged with developing MCH programs that are responsive to the needs of the community. Contractors for the FFY 2011-2015 project period were selected through a competitive request for proposals (RFP) process. Contractors include county public health agencies and private, non-profit agencies such as community action programs and hospital-based public health entities. Agencies work to align services with available funding. More information on local MCH agencies can be found in Section B: Agency Capacity.

The following section provides an overview of IDPH's significant public initiatives.
Significant Public Initiatives: Newborn Hearing Screening Program
Iowa's Early Hearing Detection and Intervention (EHDI) program is a collaborative effort of two projects, one funded by the Centers for Disease Control and Prevention (CDC) and one funded by the Health Resources and Services Administration (HRSA). The two projects work together to achieve a comprehensive and coordinated statewide EHDI system. The CDC project, which is administered by the Iowa Department of Public Health is housed at the IDPH Bureau of Family Health, Iowa's Title V program for maternal and child health. Under Iowa legislation regarding Universal Newborn Hearing Screening, IDPH is designated as the entity responsible for the collection of hearing screening and diagnostic information. The HRSA project is administered by Child Health Specialty Clinics (CHSC), Iowa's Title V program for children with special health care needs. The CHSC EHDI project focuses on assuring that all infants and toddlers that are deaf or hard-of-hearing receive timely and appropriate follow-up services. The CHSC EHDI project also provides family support including the statewide Guide By Your Side Parent Network.

Iowa's EHDI program goals include the following:
• Develop and sustain a comprehensive coordinated system of care for Early Hearing Detection and intervention in Iowa.
• Provide technical assistance to birthing hospitals, area education agencies, and private practice audiologists relative to the hearing screening program and their responsibility under the law.
• Implement a statewide of a Web-based surveillance system to assure all Iowa newborns are screened for hearing loss and receive follow up services, as needed.
• Facilitate data integration linkages with related screening, tracking, and surveillance programs to minimize infants "lost to follow-up".

• Meet the National EHDI Goal of 1-3-6.
o All infants are screened for hearing loss before 1 month of age, preferably before hospital discharge.
o All infants who do not pass the screening will have a diagnostic audiologic evaluation before 3 months of age.
o All infants identified with a hearing loss receive appropriate early intervention services before 6 months of age.
• Review data to identify children with potential for hearing loss to ensure those children receive appropriate, timely early intervention services.
• Collaborate with Individuals with Disabilities Education Act, Part C (Early ACCESS) to strengthen early intervention services for children who are deaf or hard-of-hearing.
• Ensure families with children zero to three who are deaf, hard-of-hearing, or at risk of late-onset hearing loss will be linked to a medical home and receive family-to-family support.
• Implement program evaluation that incorporates process and outcome objectives which drives system development and program improvement.

Significant Public Initiatives: Surveys
Barriers to Prenatal Care
Currently, the Department sponsors the Barriers to Prenatal Care project, a 50 question survey of new mothers before hospital discharge. The survey identifies behaviors and experiences (e.g., nutrition, stress, weight, smoking, etc.) before and during pregnancy as well as, the plans for baby care upon arriving home (e.g. sleep position, breastfeeding, etc.). In 2008 the March of Dimes funded a pilot project of PRAMS. This allowed Iowa to conduct I-PRAMS,a follow-up phone survey with new mothers four months after delivery.

IPRAMS
I-PRAMS will provide information about moms' well being after pregnancy and the families' access to newborn/well baby care as well as, the new mother's ability to follow through with their initial plans for baby care and if not, why not.. Survey participants were randomly selected among all new mothers in Iowa. The total survey sample size for the pilot was 1,800 with an overall response of 1,233 (68.4 percent). Preliminary data results based on calendar year responses are expected by late July 2010. In the future the adequacy of the available data sets will be investigated to determine future data needs for MCH surveillance.

Household Health Survey
The Iowa Child and Family Household Health Survey (IHHS) is a comprehensive, statewide effort to evaluate the health status, access to health care and social environment of children of children and families in Iowa. The first IHHS was conducted in 2000 and the second in 2005. Planning is underway for the implementation of the 2010 survey in the fall. The IHHS serves as a foundation for Iowa's five year needs assessment.

The IHHS is a collaboration between IDPH, the University of Iowa Public Policy Center and the Iowa Child Health Specialty Clinics (CHSC).

The primary goal of the Household Health Survey were to: 1) assess the health and well-being of children and families in Iowa, 2) assess a set of early childhood issues, 3) evaluate the health insurance coverage of children in Iowa and features of the uninsured, and 4) assess the health and well-being of racial and ethnic minority children in Iowa.

Significant Public Initiatives: State Child Health Insurance Program
Iowa's Covering Kids and Families (CKF) project, sponsored in part by the Robert Woods Johnson Foundation and led by IDPH's Bureau of Family Health, guided development of Iowa's SCHIP program. Iowa's CKF coordinated outreach and enrollment strategies, policy recommendations and sustainability. In response to the federal initiative of State Children's Health Insurance Programs (SCHIP), the 1998 Iowa Acts, Chapter 1196, authorized health care coverage for specified uninsured children in Iowa. Legislation created a plan that expanded

Medicaid eligibility to children whose family incomes were up to 133 percent of the federal poverty level (FPL). Iowa also chose to establish a separate private insurance plan for children with a family income between 133 percent and 200 percent of the poverty level; this program is called hawk-i (Healthy and Well Kids in Iowa.)

As part of the coordinated Iowa CKF efforts, the Bureau of Family Health became the Iowa Department of Human Services (DHS) contractor providing state level hawk-i outreach in 2002. A full-time state hawk-i outreach coordinator provides outreach coverage for state level initiatives and the local child health agencies provide outreach to all 99 counties at a community level. The local coordinators focus outreach on faith based organizations, schools, health care providers and special populations while working with key stakeholders on outreach initiatives. In the upcoming year, local coordinators will provide leadership for implementing community based presumptive eligibility described below.

In 2009, The General Assembly passed Senate File (SF) 389 directing the DHS to implement several initiatives that would expand coverage to children in both Medicaid and hawk-i and reduce barriers to enrollment. The intent of this legislation is to provide coverage for all children. The legislation
a) deemed hawk-i creditable coverage;
b) allows for the use of one pay stub as verification of income for Medicaid and hawk-i;
c) allows for the averaging of three years of income for self-employed persons to establish eligibility for Medicaid and hawk-i;
d) directs the state to complete the following for Medicaid and hawk-i :
e) utilize joint applications and the same application and renewal processes,
f) implement administrative or paperless verification at renewal,
g) utilize presumptive eligibility when determining a child's eligibility,
h) utilize the "express lane" option to reach and enroll children;
i) creates a dental-only option in hawk-i for children who have medical but not dental coverage.

Emerging from prior health reform legislation, effective July 1, 2009 eligibility for hawk-i was expanded to 300 percent FPL and Medicaid for pregnant women and infants less than one year of age to 300 percent FPL. As part of SF 389, also effective July 1, 2009, children in lawful permanent resident status may receive Medicaid or hawk-i coverage if they are otherwise eligible, regardless of their date of entry into the United States; thus eliminating the past five-year bar placed on this population. Effective March 1, 2010 hawk-i implemented the nation's first dental only program based on the CHIPRA legislation that allows states the option. The hawk-i board unanimously approved a three tiered premium structure and assured that medically necessary orthodontia was provided under the dental only program.

Also effective March 1, 2010 Iowa DHS designed and implemented a presumptive eligibility for children program that will allow "qualified entities" to become certified to make presumptive determinations through a Web-based provider portal. The Iowa Medicaid Enterprise will assist in the enrollment and training of qualified entities. All presumptively eligible children will be enrolled in Medicaid until a formal eligibility determination is made. Upon determination, they will either remain in Medicaid or enroll in the hawk-i program.

Significant Public Initiatives: Health Reform
As a result of the national and state level attention to health care, Iowa enacted a Health Care Reform bill (HF 2539) during the 2008 Iowa General Assembly. A Medical Home System Advisory Council was established from this legislation. The Council's charge is to advise and assist the Iowa Department of Public Health in implementing a medical home system for Iowa. The Health Care Reform bill provides a blueprint for the future of Iowa's medical home system that defines medical home, outlines needs for the statewide structure, and focuses on the joint principles of a patient centered medical home. The Health Care Reform bill also identifies phases for medical home beginning with children enrolled in Medicaid. The proposed outcomes for the medical home system are to reduce disparities in health care access, delivery and health care

outcomes; improve the quality and lower the costs of health care; and provide a tangible method to document whether or not each Iowan has access to health care. Health improvement goals and outcomes will be developed for children, including children with special health care needs. For children, goals and performance measures will include childhood immunization rates, well-child care utilization rates, care management for children with chronic illnesses, emergency room utilization and oral health service utilization. The medical home system for children will coordinate and integrate with existing newborn and child health programs and entities including local maternal and child health agencies, Community Empowerment and Early Childhood Iowa.

Significant Public Initiatives: Fit for Life
Iowans Fit for Life continues to develop nutrition and physical activity resources for Iowans in the areas of worksite wellness, healthcare settings, the community and schools. The four year pilot intervention in 12 communities and schools concluded in May of 2009. Iowans Fit for Life continues to collaborate within IDPH's Bureau of Nutrition and Health Promotion on the Iowa

Healthy Communities Initiative Grant Program providing technical assistance to grant recipients. Iowans Fit for Life has developed several resources and provided statewide trainings including:
1) Nutrition Environment Measurement Survey (NEMS) for restaurants, stores and vending,
2) Family Support Worker Nutrition and Physical Activity,
3) Resources for Collegiate Wellness Coordinators.
In addition a "Low-Cost Ways to Make Your Community Healthier" and "Walking With A Purpose: Walkability Audit" were created. Family Support Worker Breastfeeding Support trainings as well as the completion of three toolkits are planned. The toolkits are: 1) Worksite Wellness, 2) Health Care Provider (addressing pediatric obesity), and 3) Pick a Better Snack & ACT School and Community resources.

Through the ARRA funds, Iowa is working on the grant Communities Putting Prevention to Work: State and Territories provides funding for two initiatives.
1) Providing training to birthing hospitals to establish improved breastfeeding policy using Baby Friendly Hospital Initiative policy recommendations.
2) Developing trainings and resources for child care providers to encourage a television viewing policy limiting screen time and increasing physical activity.

Significant Public Initiatives: Building Healthy Communities in Iowa through Harkin Wellness Grants
A third round of Community Wellness Grants was initiated in FY10 and covers 11 counties. Projects include worksite wellness, community gardens, wellness centers, trail development, classroom instruction in schools on nutrition and physical activity, health improvement planning and promotion and mental health. Each community completed a project action plan as well as a policy initiative related to health promotion. A training was provided to the new grantees on coalition development in May of 2010. In FY2011, additional trainings will be provided in the areas of sustainability and evaluation.

The Health Promotion unit at IDPH is anticipating the release of a new RFP for a fourth round of Community Wellness Grants in FY11.

Children with Special Health Care Needs
Child Health Specialty Clinics (CHSC) is Iowa's Title V Program for Children and Youth with Special Health Care Needs (CYSHCN). The CHSC administrative office is located at the University of Iowa in Iowa City. Including the Iowa City office, CHSC currently supports 13 regional centers throughout the state, four of which are primarily dedicated to building an improved family-driven, youth-guided system of care for children's mental health services under a cooperative agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA).

Regional centers provide and manage a number of services for CYSHCN, including direct care

clinics, care coordination, family support, and infrastructure building services, including core public health functions (assessment, policy development, and assurance), training, program evaluation, and quality improvement. The CHSC Director, Debra Waldron, MD, MPH works collaboratively with the state MCH Director and Part C (of IDEA) Coordinator to implement and develop programs to meet the health-related needs of all Iowa children. The collaboration is enhanced by Dr. Waldron's 0.2 FTE appointment as Medical Director for IDPH's Division for Health Promotion and Chronic Disease Prevention. Dr. Waldron is a board certified pediatrician with extensive public health experience in system development and quality improvement.

CHSC's organizational capacity is continually modified to respond to changing state and federal legislation and other external factors. CHSC's vision stays constant, to assure a statewide system of care for Iowa's children and youth with special health care needs. The system is defined as containing four components: 1) direct clinical care; 2) care coordination; 3) family support; and 4) infrastructure building services.

The process for developing CHSC priorities uses a combination of structured problem identification and prioritization activities, Web-based public input opportunities, and program leadership strategic planning efforts. In formulating program priorities, consideration is given to national priorities, emerging issues, financial circumstances, collaborative opportunities, and overall environmental fluctuations. Input into program planning decisions is sought from CHSC program staff, state and community-based MCH stakeholders, and families of CYSHCN. Legislators, though generally not involved in program planning, are kept informed of major program activities that benefit their constituents. Program planning and priority setting has been supplemented by data from the 2005 Iowa Child and Family Household Health Survey and the National Survey of Children with Special Health Care Needs (2006). Both are random sample, population-based surveys planned to be repeated in 2010 and 2011 respectively. Repeated survey administration provides information about changes in family experiences over time. In keeping with current high-level interest in early childhood health and development the 2010 Iowa Child and Family Household Health Survey, will include a special focus on early childhood issues.

The population-based surveys, in combination with the problem identification and prioritization activities, have identified a number of issues important to CYSHCN and their families. Consistent with national priorities, these include child and adolescent mental and behavioral health; medical homes for CYSHCN; organization and coordination of services for families; early identification and referral; transition systems for adolescents with special health care needs; family involvement in program activities; and adequate coverage for needed services. Underlying all these issues is a continuing challenge to define CHSC's roles in addressing identified priorities in a limited resources environment. Possible roles, for example, include leadership, facilitation, participation, direct service provision, resource support, and advocacy. CHSC participates in the official budget request process used by the executive branch to guide its own budget priorities. CHSC staff participate on state boards to develop policy that impacts CYSHCN, including the State Board of Health, Local and State Empowerment Board (target population is ages zero to five years), the Governor's Medical Assistance Advisory Board (target population is Medicaid recipients), and Early Childhood Iowa (ECI).

CHSC is dedicated to infrastructure building for the purpose of system development. Infrastructure building efforts currently receiving the greatest attention include improving access to pediatric mental and behavioral services, spreading the medical home model to improve quality of care for CYSHCN, developing and implementing standards for care coordination that best meet the needs of families, implementing quality improvement methodology within all CHSC programs and services, and developing statewide systems of care for 1) family to family support 2) early hearing detection and intervention, and 3) infants born prematurely. CHSC will also focus on health service delivery and health status outcome issues related to cultural diversity. Cultural brokering, cultural diversity technical assistance, and culturally-relevant social determinants of health are also focus areas of organizational efforts. CHSC incorporates evaluation, health services research, economic analysis, and partnership building strategies --all

with an eye to positively influencing policymakers.

B. Agency Capacity

In Iowa, Title V administration is the joint responsibility of the Bureau of Family Health (BFH) at IDPH and Child Health Specialty Clinics (CHSC) at the University of Iowa. Iowa's MCH programs promote the development of systems of health care for children ages 0 to 21, pregnant women, and their families. Iowa strives for services that are collaborative, comprehensive, flexible, coordinated, culturally competent, developmentally appropriate, family-centered and community-based. The core public health functions of assessment, policy development and assurance are promoted.

Women's Health

The Women's Health Team provides direction, oversight and monitoring for the 24 local maternal health (MH) and eight family planning (FP) agencies. Systems development activities are coordinated with the IDPH Family Planning Program, the Family Planning Council of Iowa (FPCI), hospitals, schools, local boards of health, providers of adolescent health programs and statewide women's health initiatives. Technical support is provided to local MH and FP agencies. Contracts are managed with the University of Iowa Hospitals and Clinics (UIHC), Department of Pediatrics.

Local Maternal Health

Local MH contract agencies are charged with developing programs that are responsive to the needs of the community. Contractors for the FFY 2011-2015 project period were selected through a competitive request for proposals (RFP) process.

A MH logic model provides the framework for MH programs to implement services that impact key performance measures. The goal of the MH program is to improve health outcomes for pregnant women and infants. Local MH contract agencies provide prenatal and postpartum care to low-income women and other women in need. Services include risk assessment, psychosocial screening, referrals, care coordination, education, delivery planning, oral health screening, postpartum visits and presumptive eligibility for Title XIX. Performance standards have been developed to ensure the provision of quality MH service throughout the state. Local MH contract agencies also complete a Direct Care audit annually and semiannual of the service documentation in the electronic health record (WHIS).

The Statewide Perinatal Care Program provides training of health care professionals, development of care standards, consultation for regional and primary providers, and evaluation of quality of care through the state's 82 hospital facilities providing obstetrical and newborn services. The team consists of a neonatologist, a perinatologist, a dietitian, an obstetrics nurse, and a neonatal intensive care nurse. Through a contract with the University of Iowa, Department of Pediatrics, these services are provided to all birthing hospitals and more intensive services are directed toward Iowa's three tertiary care centers and 19 secondary care centers.

Des Moines Infant Mortality Center Consortium

The mission of the Consortium is to improve birth outcomes and to reduce infant mortality by enhancing maternal child health interventions to vulnerable populations. One of the consortium goals is to enhance partnerships between state and local government, maternal and infant health care providers, and the private and public sectors to provide integrated community-based care for pregnant women and their infants. The Consortium includes physicians, nurses, social workers, community leaders, and legislators. The Consortium is a collaboration between IDPH, Visiting Nurse Services (VNS) of Polk County and Healthy Start. VNS of Polk County also holds the Healthy Start project to Eliminate Disparities in Perinatal Health.

Abstinence Education

Iowa will re-evaluate the Section 510 program to determine if interpretation of the A-H guidelines are significantly modified and to decide if the state will apply for the federally reauthorized funding.

Preventing Shaken Baby Syndrome
Comprised of representatives from IDPH, Prevent Child Abuse Iowa, Iowa Department of Management, and Blank Children's Hospital, the Iowa Prevent Shaken Baby Syndrome (SBS) team collaborated to plan and implement a statewide program to prevent SBS. The team attended the PREVENT Institute for Child Maltreatment at University of North Carolina which provided education and coaching toward the development of a plan for Shaken Baby Prevention.

Efforts by child abuse prevention advocates led to the passage and signing of a bill during the 2009 legislative session, directing IDPH to develop and implement a statewide SBS prevention plan. The foundation plan from PREVENT was used to further refine a plan and pilot implementation phase. Funds received have allowed this pilot to serve birthing hospitals, in a 12-county region in central Iowa. Additional hospitals throughout the state, including University of Iowa Children's Hospital and St. Luke's Hospital in Cedar Rapids, secured independent funding and have implemented the program.

The educational program selected for use is the Period of PURPLE Crying, the only SBS prevention program having undergone randomized, clinical trials to measure its effectiveness.

Preventive and Primary Care for Children
Child Health Advocacy Team
The Child Health Advocacy Team (CHAT) has extensive experience working with child and adolescent health issues. CHAT has two primary areas of focus:
1) A core group of BFH and Oral Health program consultants provides direction and oversight to local CH contract agencies. The group addresses policy and practice to promote access to preventive health care services within CH contract agencies. Training and technical assistance is provided, key data are tracked and shared, and quality assurance initiatives are conducted.
2) A broad-based team provides a forum for communication and collaboration across IDPH programs that impact children. Representatives include consultants from the Oral Health Bureau, Bureau of Disease Prevention and Immunization, Bureau of Lead Poisoning Prevention, Bureau of Nutrition and Health Promotion, Center for Congenital and Inherited Disorders, Early ACCESS, Early Hearing Detection and Intervention, ECI, Early Periodic Screening, Diagnosis and Treatment (EPSDT), Adolescent Health, Healthy Child Care Iowa, 1st Five, hawk-i Outreach and Head Start with consultation available from the IDPH Office of Multicultural Health.

Local Child Health Agencies
Local CH contract agencies are charged with developing programs that are responsive to the needs of the community. Contractors for the FFY 2011-2015 project period were selected through an integrated competitive request for proposals (RFP) process for MCH and family planning.

A CH Logic Model provides the framework for CH programs to implement services that impact key performance measures. The goal of the CH program is to improve health outcomes for children. CH contract agencies provide infrastructure building, population-based, and enabling services to assure that children have access to comprehensive well child-screening services include oral health services, based upon guidelines established under the EPSDT Care for Kids program. Agencies provide outreach to uninsured children, education on the importance of preventive health care, and access to medical and dental care. They promote linkage to medical and dental homes and referral to needed services. Service coordination under Early ACCESS (IDEA ,Part C) is provided for children with blood lead levels of 20µg/dL or greater. Gap-filling direct care services are provided where access is limited.

Oral Health Program

The Oral Health Bureau (OHB) works to protect the health and wellness of Iowans through prevention and early detection of dental disease and through the promotion of optimal oral health. OHB staff offers consultation and assistance to local MCH contract agencies in assuring good oral health for the women and children they serve. An agreement with the DHS supports the I-Smile™ dental home initiative. I-Smile™ is the result of a state mandate that all Medicaid-enrolled children ages 0 to 12 have a dental home. The I-Smile™ program plan developed by OHB requires each CH agency have a dental hygienist serving as I-Smile™ coordinator, building support systems for families through work with dental providers, medical providers and community organizations. In addition to building local oral health infrastructure, the coordinators and other CH agency staff provide oral health promotion and education, care coordination and preventive dental services to ensure optimal oral health for children.

OHB partners with the Department of Education,school nurse organizations, local public health and Iowa State University Extension to ensure compliance with the state's school dental screening requirement, enacted by the 2007 General Assembly. I-Smile™ coordinators are integral to the process, by coordinating local efforts to audit schools and helping families meet the requirement.

A Targeted Oral Health Service Systems grant through HRSA is helping OHB to create a surveillance system and to promote oral health and I-Smile™ statewide. Open mouth surveillance has been conducted for children at Head Start/Early Head Start and WIC clinics, through the cooperation of the Iowa Head Start State Collaboration Office and the IDPH Bureau of Nutrition and Health Promotion. A public-private partnership with the Delta Dental of Iowa Foundation has been instrumental to promotion efforts, including providing funding for the broadcast of I-Smile™ public service announcements distribution of children's oral health books to pediatric and primary care medical offices.

Healthy Child Care Iowa (HCCI)
Iowa has 54 Child Care Nurse Consultants (CCNC) working a total of 28 full time equivalent (FTE) positions. Local MCH contract agencies are required to provide leadership for development of health and safety in child care. Key activities include, securing funding, developing local agency capacity for CCNC services, providing structure for services of the CCNC and establishing written agreements with Child Care Resource & Referral (CCR &R). Funding for CCNC positions comes from Child Care Developmental Funds, Early Childhood Iowa (ECI) funds, Title V funds, private and public foundations, businesses and Head Start/Early Head Start.

Early care and education providers in Iowa have voluntary access to free health and safety consultation through CCNCs. Early care and education providers participating in Iowa's Quality Rating Scale (QRS) are required to have a business relationship with a CCNC and for higher levels on the QRS are required to have onsite assessments and consultation provided.

Child Death Review Team
The Iowa Child Death Review Team (CDRT) reviews medical, investigative, and medical examiner records of all Iowa children from 0 through 17 years who died during the previous calendar year. In the 2009 General Assembly, CDRT responsibilities moved from BFH/Title V to the Iowa Office of State Medical Examiner. BFH staff worked with the Iowa Office of State Medical Examiner to transfer the program. The BFH continues to work with the CDRT but the Team has not been convened in the past year.

Sudden Infant Death Syndrome Program
Autopsies are required by Iowa Code on all children two years and younger who die unexpectedly. A contractual agreement with the Iowa SIDS Foundation covers printed information, community and professional presentations, grief counseling and referral services. A peer contact provides assistance to the family through the first year of grief following the infant's death. The Iowa SIDS Foundation operates eight grief support groups across the state. The contractual agreement with the Iowa SIDS Foundation is expected to continue in FFY2011.

Center for Congenital and Inherited Disorders
In 2004, state legislation was passed that renamed the Birth Defects Institute and some of its programs. The Institute is now called the Center for Congenital and Inherited Disorders (CCID). Programming from the CCID includes: Iowa Registry for Congenital and Inherited Disorders Regional Genetic Counseling Services, Iowa Neonatal Metabolic Screening Program (INMSP), Maternal Serum Alpha-fetoprotein (MSAFP) screening program and the Neuromuscular and Related Disorders program.

With the possible addition of cystic fibrosis carrier screening as part of the MSAFP, and cystic fibrosis screening as part of the INMSP, the genetics program staff has been working closely with the Pulmonology and Allergy Department staff at the University of Iowa.

The CCID has developed a code of ethics to guide decision-making and policy development. Stillbirth prevention activities continue along with the stillbirth surveillance program at the IRCID. The registry has been expanded to conduct surveillance of confirmed newborn screening cases. CCID continues to increase family and health provider participation in the planning, implementation, and evaluation of the newborn screening programs through the Iowa Family Participation Project, via a HRSA MCHB cooperative agreement.

Early Hearing Detection and Intervention (EHDI) Program
Iowa continues to make substantial progress in development of a comprehensive EHDI system. Significant accomplishments and areas of ongoing development include:
• state legislation regarding universal newborn hearing screening,
• collaborative relationships with key partners,
• an established advisory committee,
• statewide implementation of a Web-based data system,
• statewide implementation of a referral and follow up program, including early intervention that is culturally sensitive to the needs of Iowa's population,
• development and implementation of a family support program,
• reporting protocols that guide program development,
• quality assurance plan that promotes program consistency and accuracy,
• program evaluation that incorporates process and outcome objectives, and
•preliminary sustainability plan addressing the future of Iowa's EHDI system.

The IDPH EHDI project partners with the Center for Disabilities and Development's Iowa's Leadership in Neurodevelopmental and related Disabilities (I-LEND) program for audiological training, technical assistance to EHDI screeners and audiologists, and assistance in developing EHDI protocols. The CHSC EHDI project partners with Iowa Hands and Voices, as well as other family support programs in the state to ensure families are connected to other parents and support services in their communities.

Iowa Collaboration for Youth Development (ICYD)
The Iowa Collaboration for Youth Development Council (ICYD) is a state-led interagency initiative designed to better align policies and programs and to encourage collaboration among multiple state and community agencies on youth-related issues. The goals of the initiative are to promote the use of positive youth development principles in state policies and programs and to facilitate the use of effective youth development practices in communities throughout Iowa.

State of Iowa Youth Advisory Council (SIYAC)
The State of Iowa Youth Advisory Council (SIYAC) is a non-partisan policy advising organization comprised of youth from across the state. The council meets quarterly in Des Moines and all members are active in local youth groups, organizations, councils or committees in their schools and communities.

Over the years, several state agencies within the Iowa Collaboration for Youth Development have

supported SIYAC by offering staff support, allowing employees to serve as mentors, and by using the collective SIYAC voice to help guide state-wide projects impacting youth.

Improving Academic Achievement by Meeting Student Health Needs
The Iowa Interagency Health Promoting Communities and Schools team developed "Improving Academic Achievement by Meeting Student Health Needs". The purpose of the briefing was to gather scientific-based research supporting school health promotion to improve academic achievement.

The Departments of Education, Public Health and Human Services work together to advance initiatives in coordinated school health. Priority actions are being addressed to improve student health and academic outcomes. The first goal of the interagency collaboration is to focus on school wellness. The Joint Statement and team members can be found at http://www.iowa.gov/educate/index.php?option=com_content&task=view&id=583&Itemid=1614#School

Prevention of Youth Violence
Iowa's primary focus is to strengthen prevention of self-directed and interpersonal child and adolescent violence. These include such behaviors as suicide, child maltreatment, school violence, community violence and bullying. Comprehensive and sustained support of youth is necessary to improve youth outcomes and reduce suicide and interpersonal violence. The overarching theme of the violence prevention effort will be youth development. Youth development goes beyond problem reduction and applies to prevention, remediation and treatment, participation and involvement and academic and workforce preparation.

Culturally Competent Care for MCH Populations
The Office of Multicultural Health is housed in IDPH's Division of Health Promotion and Chronic Disease Prevention and is codified within legislative code 2734. Section 74. 135.12. The office is responsible for bridging communication, service delivery and practical approaches to issues encountered by organizations and communities working to address the needs of Iowa's diverse populations. Comprehensive management strategies are used to address culturally and linguistically appropriate services, including strategic goals, plans, policies and procedures, arranging for ongoing education and training for administrative, clinical and other appropriate staff, and providing identification of resources and programs to increase awareness of health equity and competent health care and service delivery.

The OMH has formed numerous partnerships providing leadership, training, technical assistance and representation to assure health equity, culturally sensitive and appropriate actions and reduce identified disparities.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS
Child Health Specialty Clinics (CHSC) uses an organizational structure of 13 regional centers to provide family-centered, community-based, coordinated services to Iowa children and youth with special health care needs (CYSHCN) and their families. In addition to the 13 regional centers, the CSHC administrative office is located in Iowa City.

In 2010 CHSC adopted a new vision statement to assure a system of care for Iowa's children and youth with special health care needs. Iowa's new state performance measure #2 will assess the degree to which components of the system of care are present within CHSC. CHSC's system of care has been defined as having four components (direct clinical services, care coordination, family support, and infrastructure building). Descriptions regarding CHSC's capacity to assure each component of the statewide system are provided below. Key collaboration with community and state partners to maximize resources that contribute to the system of care are also described.

Direct Clinical Services

The term "CHSC Clinical Services" was created in 2010 to holistically refer to all clinical services CHSC provides. This new terminology replaced two former distinct clinic titles that were viewed as unique cornerstones to CHSC clinical services: 1) Integrated Evaluation and Planning Clinic (IEPC) and 2) Birth to Five Services (B-5). A 2007 program evaluation of the IEPC revealed that local discretion produced a non-standardized, irregular clinical service that sometimes failed to meet current practice standards. Therefore, CHSC began efforts to standardize the referral, staffing, diagnostic, therapeutic and follow-up processes for the IEPC service across regional sites. Such standardization was also realized to be beneficial for the B-5 Services.

Any child or youth ages 0 to 21 can be served through CHSC Clinical Services (CS). Many children with behavioral and emotional health needs receive evaluations and recommendations. CS is an important platform for family access to intensive care coordination, as well as to child psychiatry consultation via telemedicine communication. CS regional center staffing includes some or all of the following: an advanced registered, nurse practitioner or nurse clinician, registered dietitian and a parent consultant. Collaborations may occur with an Area Education Agency psychologist and/or speech and hearing professional and a contracted or DHS social worker. Many children seen in CS have complex behavioral or emotional problems that were not successfully addressed by parents, educators or primary care physicians.

An additional population served through CS is children in the early childhood system. CS provides developmental screening, assessment and follow-up for young children at-risk for developmental delay. Recommendations and family support are provided, as is care coordination, if needed. Advanced registered nurse practitioners with expertise in care and management of young children with special health care needs, staff nurses, registered dietitians, and parent consultants who are themselves parents of children with special health care needs are the provider. For children at risk for developmental delay in growth, motor skills, language and social interaction; children subjected to abuse or neglect; and children exposed to drugs during pregnancy or later at home CS also connects families to Early ACCESS (IDEA, Part C).

CS seeks to connect all children served to medical homes by local primary care providers, while facilitating appropriate referrals to subspecialists through effective care coordination. Through CHSC's network of parent consultants and the newly formed Family to Family Health Information Center (now named Family to Family Iowa), families are matched with other families who can best provide peer support and teach skills to help them becomes their child's primary navigator and advocate.

CS currently performs essential surveillance functions re development, social-emotional skills, and nutrition. As of mid-2008, all CS screen for autism spectrum disorder using the Modified Checklist for Autism in Toddlers (M-CHAT). In 2010 CHSC's Regional Autism Services Program (RASP) reported a doubling of the number of autism spectrum disorder screenings of children 18-36 months seen in CHSC clinical settings. ARNP's, staff nurses and parent consultants are also trained in the evidence-based screening tools Ages and Stages Questionnaire (ASQ) and ASQ-Social Emotional (SE), and the Developmental Assessment of Young Children (DAYC). Registered Dietitians and other CS staff also implement the PEACH tool, a screening tool to detect feeding and nutrition needs of infants and toddlers. CHSC has conducted statewide training with the Early ACCESS to implement use of the tool. Work is also underway to use parent consultants to conduct hearing re-screens in selected areas of the state for children who missed the birth screen.

CHSC registered dietitians (one full-time staff and two 0.5 FTE) provide specialized nutrition services for infants and toddlers whose needs are identified on the PEACH tool.

Care Coordination Services

CHSC's Health and Disease Management (HDM) Unit, composed of both nurses and parent consultants, is designed to help families evaluate a child's needs and obtain services. Since

1985, CHSC has had an agreement with DHS to assist with care coordination of CYSHCN eligible for the Medicaid III and Handicapped Waiver. Now, care coordination is provided for children enrolled in Medicaid's consolidated Waiver Program.

General care coordination is also available for every CYSHCN and family enrolled in the CHSC Clinical Services (CS). ARNPs, staff nurses, social workers, registered dietitians and parent consultants provide the team of available care coordinators to best meet the family's needs as they evolve. Science of improvement (quality improvement) techniques are being developed to assure care coordination standards, staff training, and appropriate data tracking that includes family satisfaction.

A major care coordination initiative is facilitating linkages of all primary care practices in the state --pediatric and family medicine --to community-based care coordination resources, most of which are affiliated with the Title V Program. The 1st Five was initiated as part of an MCHB-supported Integrated Community Systems grant.

Care coordination to meet the needs of children and youth, birth to age 21, who struggle with emotional/ behavioral challenges is provided by Community Circle of Care (CCC). CCC is a system of care initiative to build local resources, services, and supports to keep children in their own homes, with their families, and in their own communities, avoiding costly and inefficient out of home treatment or hospital placements. The CCC serves more than 550 newly enrolled youth in clinical services annually, providing medical assessment, treatment planning, care coordination, and medication management services to stabilize the youth. Once stable, the youth is transitioned back to their medical home, while continuing supports and care coordination as needed to keep the family successful. The CCC also provides parent to parent support, leadership and advocacy opportunities and group supports for youth and families.

The CHSC Parent Consultant Network also provides staff to support Early ACCESS (IDEA, Part C). Selected CHSC parents function as service coordinators for medically complex children ages 0-3, enrolled in Early ACCESS.

CHSC care coordinators also link with other "family navigators" throughout the state through resources made available from the Family 360 subcontract with the DHS. Three Navigators staff work with families and youth to connect them with appropriate community resources, self-advocacy skills, and support networks. Family 360's Project Director and three positions are supported through 2014 by a federal grant from HHS Administration for Children and Families.

Family Support Services

The CHSC Parent Consultant Network (PCN) is affiliated with the CHSC regional centers and utilizes parents of CYSHCN to serve as community-based consultants to other parents and families. Two family participation coordinators, both PCN members, function as leaders who work to assure family participation in all aspects of program planning and policy development. They also provide family participation data, explore resources, participate in needs assessments, develop training materials, assure competencies of the PCN, promote collaboration and organize family advocacy efforts.

Families play a large role in system development activities. For example, CHSC community-based parent consultants serve on the following state level groups: Medicaid's Medical Assistance Advisory Committee, Iowa Collaborative Safety Net Provider Network, Iowa Council on Early Intervention, Governor's Council on Developmental Disabilities, University of Iowa Center for Disabilities and Development's Community Partnership Advisory Council, the University of Iowa Hospitals and Clinics' Family Advisory Committee and local and county governance boards to guide Community Circle of Care (CCC).

CHSC obtained MCHB funds in 2009 to create Iowa's Family-to-Family Health Info Center which will enhance the mentoring, resource sharing, and parent-professional partnering of CHSC and

other family advocacy efforts. Now renamed Family to Family Iowa, the decision-making body is an interagency collaborative group of 15 family advocacy groups. Additionally, funds from Health and Human Services' Administration for Children and Families in 2009 were granted to the IDHS to conduct a Family Navigator 360 Project. DHS subcontracts with CHSC to collaborate with and supplement activities of Family to Family Iowa. The F360 five-year project will support the participation of family navigators and the spread of effective navigation techniques and knowledge of family resources through a target network of 70 navigators.

Through a collaborative project with the Center for Disabilities and Development at the University of Iowa, five CHSC parent consultants have been trained to assist behavioral health professionals to teach parents of children with autism spectrum disorder, applied behavior analysis techniques.

Infrastructure Building Services
CHSC is increasingly involved with a variety of activities to improve service system quality and capacity. CHSC is a leader and participant in efforts to both improve program-specific operations and meet larger scale community and state needs. The CHSC Public Health Division is the organizational structure that guides and facilitates CHSC's infrastructure building activities. The fundamental core public health functions of assessment, policy development and assurance have been strengthened in the programmatic and environmental awareness of leadership staff. Considered one of the four systems components of the statewide system of care for CYSHCN, infrastructure-building efforts will be monitored by the NICHQ Title V Index for the next five years.

Active projects of CHSC's infrastructure building efforts include: implementing quality improvement methodology through all programs and services of CHSC; assisting with the design, development, implementation and evaluation of systems of care for children with autism spectrum disorder, hearing loss, and premature infants; development of a new model to expand access to pediatric mental health services; implementation and evaluation of the medical home and adolescent transition projects; developing a CHSC system for the delivery of effective, efficient care coordination that is data driven; serving on Early Childhood Iowa and other decision-making groups that determine policy for early childhood; memberships on public health conference planning committees to assure topics for CYSCHN are included in key agendas; facilitating use of innovative technology throughout all levels of CHSC to further communication among staff located throughout the state and to enable effective partnering between interagency partners at the state and local level; participating in the design of the state's 2010 Household Health Survey. CHSC also partners in system development efforts with the Early ACCESS program. A portion of federal ARRA funds distributed to CHSC through Early ACCESS program is being used to document and modify the social determinants of health (SDOH) that increase the risk of negative outcomes for Iowa's early childhood population. Funds are also being used to study the effects of environmental toxins in early childhood development and provide recommendations to policymakers.

CHSC is increasing attention to cultural diversity and cultural competence in several major program areas: 1) The Early Hearing Detection and Intervention project will hire a cultural broker to advise on follow-up issues for minority children identified with hearing loss; 2) A new Hispanic Early ACCESS service coordinator was hired in N.W. Iowa to serve eligible young Hispanic children and their families; 3) The white paper on social determinants of health will include issues of cultural diversity, to encourage policies promoting healthy outcomes for all of Iowa's early childhood target population; 4) The cultural broker for the SAMHSA system of care mental health project will continued to focus on inclusion for Iowans living in rural poverty; 5) The Family-to-Family Health Info Center project will identify and address cultural and linguistic competence technical assistance needs for its family information-sharing and mentoring initiatives; 6) ARRA funds to CHSC from Early ACCESS will invest in Reach Out and Read materials that will target primary care practices who serve high numbers of ethnic minorities; 7) New state performance measure #2 contains quality measures in each of the four systems of care components that address cultural competence and the Public Health Division has assigned staff to renew the efforts to continually assure cultural competence in all program services and organizational

structure.

C. Organizational Structure

The Iowa legislature designated the Iowa Department of Public Health (IDPH), a cabinet level agency, as the administrator for Title V and maternal and child health (MCH) services. The legislature also directs IDPH to contract with Child Health Specialty Clinics (CHSC), based at the University of Iowa, Department of Pediatrics, as the state's Title V services for children and youth with special health care needs (CYSCHN) program. Statutory authority identified in the Code of Iowa (Chapter 135, Iowa Administrative Code 641, Chapter 76) provides further reference for the purpose and scope of Iowa's program. Legislative authorization for state expenditure of federal funding under the federal block grant is identified in House File 820 of the 2010 Session of the Iowa General Assembly. Contracts between IDPH and CHSC outline the responsibilities of both agencies for fulfilling the mandate for maternal and child health services. Copies of the contracts are available upon request. Additional State of Iowa statutes relating to MCH and CYSCHN programs are listed in the attachment.

The IDPH Division of Health Promotion and Chronic Disease Prevention includes the Bureau of Family Health (BFH), the primary MCH unit within the state. Responsibility for the administration of the Title V Block Grant lies within the BFH. Tables of organization illustrate the relationship of the division and the bureau within IDPH. It can be found in the Attachments. The bureau also administers a portion of the state's Title X Family Planning services. The organizational structure of the Bureau of Family Health has remained stable in recent years, while IDPH itself has experienced organizational change. In January 2007, Governor Chester Culver, became Iowa's new governor. There were also many new legislators that started the session with Culver and also a democratic led House of Representatives and Senate. Iowa has not experienced this type of change in several decades. Governor Culver appointed Thomas Newton, MPP, REHS, as the Department of Public Health Director, in April of 2007. Director Newton retained the existing IDPH organizational structure but added a new Bureau of Communication and Planning and a Deputy Director, Mary Jones.

Bureau of Family Health
Organizational structures within Bureau of Family Health (BFH) include the Women's Health Team (WHT) and the Child Health Advocacy Team (CHAT). Public health functions relating to the health of mothers, children, and families are centered in the BFH. The BFH and Title V program provide support for the department's Office of Multicultural Health co-located within the Division of Health Promotion and Chronic Disease Prevention support integration of cultural competence into program development. Areas of work for these teams include system planning, standards of care development, contract management, and coordination of health-related services. Both teams collaborate with the Iowa Department of Human Services (DHS), the Iowa Department of Education (DE), and the Iowa Regents Universities. The BFH contracts with local child health and maternal health agencies and health care providers to manage MCH programs at the local level. Listings of current contractors are located in the attachment. The BFH collaborates with the Oral Health Bureau (also a branch of the Division of Health Promotion and Chronic Disease Prevention, IDPH) to issue a joint Request for Proposal (RFP). The RFP is issued to community-based organizations interested in providing public health services for MCH and Family Planning. The RFP requires contractors to link with the Bureau of Local Public Health Services, Bureau of Immunization and TB, Early ACCESS (IDEA, Part C), Healthy Child Care Iowa, hawk-i (S-CHIP) and the Lead Poisoning Prevention Program.
Selection is based on applicant's ability to meet criteria in the areas of access, management, quality, coordination, and cost.

Administration of Programs Funded by Block Grant Partnership Budget
IDPH is responsible for the administration of all programs carried out with allotments under Title

V. A genetics coordinator of the Center of Congenital and Inherited Disorders (CCID) is housed in the Bureau of Family Health and coordinates with the Early Hearing Detection and Intervention program.

The lead program housed in the Division of Environmental Health partners with the BHF and local maternal and child health agencies on improving the incidence of lead poisoning among young children. The lead coordinator serves on the BFH CHAT team to improve system integration of child health programs.

The Immunization program is part of the Bureau of Disease Prevention and Immunization and partners with the BHF and local maternal and child health agencies on improving immunization rates. A staff person from the immunization program serves on the BFH CHAT team.

As part of the maternal health program there is support for the perinatal review team to help improve the perinatal infrastructure. The Team is led by at the University of Iowa. There is also support for the Barriers to Prenatal Care Survey through the Title V block grant. This project is a cooperative venture of all of Iowa's maternity hospitals, the University of Northern Iowa Center for Social and Behavioral Research, and the Iowa Department of Public Health.

Child Vision Screening, Iowa KidSight, is currently one of 18 state-wide preschool vision-screening programs carried out by volunteer Lions Club members. The program is administered through the University of Iowa, Department of Ophthalmology and Visual Sciences. Any young child living in Iowa is eligible for the service. There is no cost to families to participate. State funds also support activities with Prevent Blindness Iowa.

Responsibility for coordinating Iowa's program for CYSCHN is administered by the IDPH Division of Health Promotion and Chronic Disease Prevention through a contract with the University of Iowa, Department of Pediatrics. Within the University of Iowa, Child Health Specialty Clinics (CHSC) has responsibility for administration of the contract. A table of organization for CHSC is located in the attachment.

Child Health Specialty Clinics
Responsibility for coordinating Iowa's program for children and youth with special health care needs (CYSHCN) is administered by the lDPH Division of Health Promotion and Chronic Disease Prevention through a contract with the University of Iowa, Department of Pediatrics. Within the University of Iowa, Child Health Specialty Clinics (CHSC) has responsibility for administration of the contract. A table of organization for CHSC is located in the attachment.

Responsibility for family-centered, community-based, coordinated care for CYSHCN is placed in the CHSC statewide system of regional child health centers. Since 1976, the regional centers have provided multidisciplinary community-based resources for children with complex health and health-related problems. The regional centers support specialized diagnostic and evaluation services, care coordination services, family support, and infrastructure building efforts. The centers are permanently staffed by advanced registered nurse practitioners, nurse clinicians, parent consultants, and support staff. A map of the CHSC regional centers, in addition to other general program information is located at www.uihealthcare.com/chsc. CHSC's Director is a pediatrician who also functions as chief medical officer.

CHSC has history of managing several federal grants and contracts that build systems of care for CYSHCN. In prior years multiple grants had fallen under the general heading of the Iowa Medical Home Initiative (IMHI), which ultimately strived to meet the national goal of enrolling all CYSHCN in a medical home. Another MCHB-funded grant, which ended in 2005, directed CHSC to build a system of adolescent transition services to promote, among other system improvements, the medical home model for adolescents with special health care needs. Although the grants have ended, CHSC will continue involvement in statewide spread of the medical home model by offering its care coordination expertise and service to community-based primary care providers

serving CSHCN. CHSC has also secured MCHB funds to implement Iowa's Family-to-Family Health Information Center which can be another resource to emerging medical homes seeking to become more family-centered. CHSC leads an MCHB grant to provide follow-up to infants and toddlers identified with hearing loss. In collaboration with IDPH's CDC EHDI funds, CHSC is developing Iowa's EHDI system of care. CHSC parent consultants work with families of children with autism spectrum disorder to teach them applied behavior skills through a partnership with the University of Iowa's Center for Disabilities and Development's NIH-funded project. CHSC collaborates with the DHS to create a statewide system of care for children and youth with serious emotional disorder through a SAMHSA Children's Mental Health Initiative.

New ARRA-supported contracts between CHSC and Iowa's Early ACCESS (Part C, IDEA) program have expanded CHSC's role in improving and influencing early childhood programs. Some examples are: increased service coordination for infants and toddlers enrolled in Part C; systems-building efforts such as quality improvement for infants born prematurely; evaluating the effects of environmental toxin exposure on early child development; promoting early childhood literacy; studying early childhood risk factors associated with selected "upstream" social determinants of health, and exploring the use of telemedicine to deliver in-home nutrition services to infants and toddlers ages 0-3.

An attachment is included in this section.

D. Other MCH Capacity

MATERNAL AND CHILD HEALTH

The administrative office for Iowa's Title V program is housed within the Iowa Department of Public Health located on the State Capitol complex in Des Moines, Iowa. The IDPH employs the Bureau of Family Health Chief and Title V Director, a Division Medical Director, and 26 professional and four support staff who manage the functions of Iowa's Title V program. In addition, Title V in cooperation with EPSDT, supports the State Dental Director (DDS) and four public health hygienists (RDH). Tese staff are based in central office. The department contracts with 24 local maternal health agencies and 22 local child health agencies to provide community-based MCH services throughout the state. For additional information about the responsibilities and structure of the local contract agencies, see section IIIB Agency Capacity.

Bureau of Family Health (BFH) staff members provide the capacity for policy development, program planning and evaluation functions. Data reporting and analysis functions are provided through the capabilities of staff in the IDPH Bureau of Information Management (BIM) and a senior statistician now assigned to the BFH. The IDPH Center for Health Statistics (CHS) has been decentralized. The senior statistician provides the data as a CHS staff person will continue to perform analysis for Title V programs as a BFH staff member. A BIM staff member serves as liaison to the BFH and focuses on data integration efforts for the major MCH data systems in Iowa.

The Bureau of Family Health and the Center for Health Statistics have established an agreement with CDC to have an MCH Epidemiologist assigned to Iowa. Dr. Debbie Kane will assist the Department by providing consultation, technical assistance, surveillance and analysis of epidemiological information for Iowa's MCH population. Initial activities have focused on needs assessment and data integration and data linkages.

Medicaid Administrative Services

Due to recent changes in the federal definition of targeted case management (TCM), Iowa Medicaid submitted an amendment to their state plan to change EPSDT informing and care coordination and maternal health presumptive eligibility and care coordination from TCM to administrative services. Through a contract between Iowa Medicaid and the Bureau of Family Health, presumptive eligibility, informing, and care coordination are billed to the BFH on a fee-for-service basis with a full review of documentation done before payment is made. Four new staff

members were hired to conduct quality assurance reviews of the service documentation provided with the billing. The new staff members also conduct technical assistance with local MCH agencies on documentation, other quality assurance activities, and billing processes.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Iowa's Title V Program for CYSHCN, Child Health Specialty Clinics (CHSC), is an administrative responsibility of Iowa Department of Public Health (IDPH), Division of Health Promotion and Chronic Disease Prevention, managed through a contract with the University of Iowa, Department of Pediatrics. CHSC maintains an Iowa City administrative office, as well as 13 regional centers located in or near the state's population centers. Of the total staff complement, there are currently 22 staff in Iowa City and 100 staff located in the other 13 CHSC regional centers or in telecommuting status.

The capacity to perform core public health functions is shared among professional and support staff. Public Health Division Unit staff have education and experience in public health science and practice and science of improvement methodology, and take a lead role in coordinating core public health activities. Families of CYSHCN add program capacity through the Parent Consultant Network (PCN), a community-based network of part-time parent consultants affiliated with the regional centers. CHSC's family participation program is led by two experienced members of the PCN. They lead the PCN by advising on policy and program planning, recommending training, monitoring activity, and updating resource information. All parent consultants undergo a structured basic training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports. In addition they are also trained to perform specific tasks related to their unique roles, e.g. autism, Early ACCESS (Part C IDEA), Family Navigator, Ill and Handicapped Waiver, Community Circle of Care, etc).

External contracts and grants have increased CHSC's capacity to contribute to prescribed priorities. Contracts with the Iowa Department of Education Part C Program have expanded CHSC's participation in the areas of early intervention (especially system development and quality assurance) service coordination, and delivery of nutrition services. New ARRA-supported contracts between CHSC and Iowa's Part C early intervention program have increased CHSC's role as service coordinator for infants and toddlers enrolled in Part C as well as other projects that address eligibility (e.g. addressing early childhood risk factors associated with selected "upstream" social determinants of health and exposure to environmental toxins).

Contracts with the Iowa Department of Human Services commit CHSC to provide care coordination to "medically fragile" children enrolled in Medicaid Waiver Programs and to develop a system of Family Navigators for the state.

CHSC is contracted to lead the clinical care component of a major system improvement effort in ten counties of NE Iowa for children with severe emotional disorders. This six year effort, ending in 2012, is intended to produce a sustainable model that can successfully spread to the entire state.

Another significant element of program capacity relates to service billing. CHSC professional services are systematically billed at levels that accurately reflect the intensity and skill of the service. A sliding fee scale continues to be employed to determine family liability.

LEADERSHIP

Senior level management employees are M. Jane Borst, Iowa Title V Director and Chief of the Bureau of Family Health and Dr. Debra Waldron, Director of Child Health Specialty Clinics and its Chief Medical Officer. Their qualifications appear in brief biographies attached to this section. Debra Waldron, MD, MPH, also serves as the medical director for the Iowa Department of Public Health's Division of Health Promotion and Chronic Disease Prevention.

An attachment is included in this section.

E. State Agency Coordination

The following descriptions highlight significant organizational relationships within Iowa that enhance the capacity of the Title V program. These descriptions do not capture extensive coordination efforts undertaken by the state's Title V program. A complete listing of formal and informal organizational relationships is located in the attachment.

Special Supplementary Nutrition Program for WIC

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) coordinates with maternal and child health (Title V) services at the local level to provide comprehensive services to low-income women and children. Service can include but are not limited to:

1. Collaboration on identified nutrition issues for women related to issues such as maternal gestational diabetes and breastfeeding.
2. Providing a consistent message to parents receiving both WIC and Title V Services
3. Collaborating with oral health services including a Registered Dental Hygienist in WIC clinics to avail families of oral health counseling relating to nutrition, receiving fluoride varnish, and dental referrals.
4. Collecting samples for lead screening when collecting hemoglobin for the WIC program and then having the availability of Registered Dietitians if a high serum led is identified to provide nutrition counseling.

The Bureau of Nutrition and Health Promotion coordinates the nutrition components of MCH projects and provides staff assistance. Training, consultation, and educational programs are provided for all MCH programs.

Family Planning

The Title X Family Planning Program is housed in the Bureau of Family Health. Forty-five of the counties are served by IDPH. The other forty-five are served by Family Planning Council of Iowa. The IDPH Family Planning Program works closely with the Family Planning Council of Iowa to create efficiencies in carrying out required functions. IDPH works closely with the Department of Human Services in carrying out the 1115 Medicaid Waiver program, or Iowa Family Planning Network (IFPN). Title X family planning clinics may register IFPN clients on site. From February 1, 2006 to December 31, 2009, approximately 81,113 females were enrolled into the IFPN program. A benefit cost analysis of publically funded family planning services in Iowa based on 2009 data revealed that the ratio of benefit to cost for a one year time period is 3.78 -- that is, for every dollar spent on family planning $3.78 is saved in averted costs. Analyzing a 5-year time frame, the ration of benefit to cost increases to 15.12. Within age categories, the greatest cost savings appear among teen mothers wherein $4.34 is averted for every dollar invested in family planning. IDPH participates with the Iowa Initiative to Reduce Unintended Pregnancies, a statewide project to reduce unintended pregnancies in Iowa in women ages 18 to 30. The Iowa Initiative is a multi-year, foundation-supported effort. In 2008, legislators passed legislation an appropriation for the development of the State Funded Family Planning (SFFP) program. Women who are not eligible for IFPN because of age, insurance coverage (that does not cover family planning services) or who are citizens but cannot document citizenship may qualify for SFFP program services. Unfortunately, an across the board 10 percent state budget cut resulted in discontinuation of the SFFP program in 2009. IDPH expects the loss will result in an increased need for Title X services or a gap in services.

IDPH and Iowa DHS Agreements

Iowa DHS and IDPH work together to establish multiple agreements for initiatives that are mutually beneficial for the populations served. The following agreements initiated by DHS reflect the collaborative partnership between these state agencies.

DHS Cooperative Agreement

IDPH, Division of Health Promotion and Chronic Disease Prevention, maintains an ongoing

cooperative agreement with DHS. The agreement defines coordinated efforts toward an integrated system of high quality, comprehensive, cost-effective, adequately financed health services for Medicaid members.

DHS Agreement for EPSDT Care for Kids , Maternal Health, and Oral Health Services
State agency coordination is necessary in order to assure that families receive appropriate services. The IDPH provides services for the EPSDT Care for Kids program and the Maternal Health program under an intergovernmental agreement with DHS. Under this agreement, local child health contract agencies are approved as Medicaid Screening Centers, and local maternal health contract agencies are approved as Medicaid Maternal Health Centers. The I-Smile dental home initiative serves to improve access to Medicaid's dental prevention and treatment services for children and pregnant women. Local Title V agencies are able to bill Iowa Medicaid for covered services provided to Medicaid members.

Local care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the services available under the EPSDT program and the importance of regular well-child and dental exams. DHS downloads information on Medicaid enrolled children into the Child and Adolescent Reporting System (CAReS), which is then available to local child health contract agencies.

Local MH agencies provide services for pregnant women according to standards established by the American College of OB/GYN for ambulatory obstetric care. MH services include medical and dental assessment, health and nutrition education, psychosocial screening and referral, care coordination, assistance with plans for delivery and postpartum home visiting.

Assurance of medical and dental homes for regular preventive health care for pregnant women and children remains a cornerstone of the work accomplished by local contractors. Care coordinators partner with local practitioners to establish medical and dental homes. Local MCH contract agencies provide limited gap-filling direct care services based upon local need.

DHS Agreement for Administrative Services
The administrative services agreement between IDPH and DHS provides funding for IDPH to pay fee-for-service claims for EPSDT informing and care coordination services as well as maternal health presumptive eligibility and care coordination provided by local contract agencies. This payment process began for services provided in February 2009 due to classification of these services as ‘administrative' under Medicaid. IDPH has implemented billing procedures, established parameters for quality assurance review of claims prior to payment and provided technical assistance for local contract agencies.

DHS Medicaid Outreach Agreement
The purpose of this interagency agreement is to maintain the toll free 1-800 information and referral line known as the Healthy Families Line. The line distributes health information that meets the individual's needs. The service connects the caller directly to their local MCH contract agency where care coordinators can assist the caller to link with local resources.

DHS hawk-i Outreach Agreement
Since its implementation in 1997, nationally, state CHIP programs have provided health care coverage to millions of uninsured children. In Iowa, DHS is responsible implementing and monitoring the State's Children's Health Insurance Program (hawk-i). DHS contracts with IDPH for localized hawk-i grassroots outreach.
Over the previous years, IDPH, DHS and local MCH agencies have built upon the successes from previous years in providing grassroots outreach to the local communities. The state and local partnerships have also made new gains in targeting newly eligible uninsured families.

DHS Medicaid and Vital Records Linked Data Agreement
In 1989, Iowa legislation directed DHS to evaluate the Medicaid program's effectiveness in

serving low-income pregnant women. To examine the pregnancy and birth outcomes of women receiving Medicaid benefits, Medicaid claims data and birth certificate data are needed. An annual inter-departmental agreement is executed by DHS to provide Medicaid claims data to the IDPH. IDPH staff link Medicaid claims data to birth certificate data. The results are used to examine access to prenatal care and preventive dental care for pregnant Medicaid women, as well as to compare birth outcomes of those on Medicaid to non-Medicaid members.

hawk-i (Healthy and Well Kids in Iowa)
For the past eight years, DHS has contracted with IDPH to provide grassroots outreach and enrollment for hawk-i. IDPH continues to contract with 22 local CH agencies to conduct grassroots hawk-i outreach and focus on children's enrollment. The successful collaboration between IDPH and DHS continues to guide successful outreach to uninsured families in Iowa. Outreach efforts focus on four areas: schools, health care providers, faith-based organizations and special populations. Additional efforts have included businesses, workforce development, chambers of commerce, insurance agents, tax preparation sites and many other areas.

As a result of the recent implementation of Iowa's hawk-i dental only program and the presumptive eligibility for children program, outreach has expanded to several new community partners. DHS and IDPH have partnered with the Department of Education in relation to the presumptive eligibility for children program. School nurses in all of Iowa's school districts will potentially be certified as qualified entities to determine children presumptively eligible for hawk-i or Medicaid. Other entities may include hospitals, primary care physician offices, rural health centers, federally qualified health centers, area education agencies, Early ACCESS service coordinators and Indian health providers.

In light of the recent reductions in the workforce and increasing unemployment rates, coordinators have focused on strengthening the collaboration with Iowa Workforce Development centers, temporary employment agencies and community job loss rapid response teams.

Preventable Diseases Program
The Bureau of Immunization and Tuberculosis administers the program for vaccine preventable diseases. Vaccines are available to local health departments, child health agencies and private physician's offices for required childhood immunizations. The Immunization Registry Information System (IRIS), a web-based registry, now serves the state's public sector clinics and private providers. The BFH, Immunization and TB and DHS collaborate to promote statewide utilization of the registry in both public and private clinics.

Childhood Lead Poisoning Prevention Program
Since nearly 40 percent of the state's housing was built prior to 1950, IDPH recommends all Iowa children under the age of six receive routine blood lead testing. Local contract agencies, local health departments and private practitioners test children. IDPH educates private practitioners about the importance of testing children for lead poisoning. Case management of children with lead poisoning is a collaborative effort of the Childhood Lead Poisoning Prevention Program, the Bureau of Family Health, local contract agencies and local health departments.

Bureau of Local Public Health Services
The bureau was established to strengthen the public health delivery system in Iowa at both the state and local level through education, consultation, support and technical assistance for local boards of health and local health systems. The capacity of Iowa's local boards of health are increased through local health departments, public health agencies, programs and services. Increased capacity promotes healthy people in healthy communities. Regional community health consultants provide training and technical assistance to local public health agencies regarding assessment of their community's health needs and creation of health improvement plans. Technical assistance and education is also provided to local boards of health by the consultants to assist in preparation for meeting the Iowa Public Health Standards developed through Public Health Modernization in Iowa.

Iowa Center for Congenital and Inherited Disorders
The Center for Congenital and Inherited Disorders (CCID), in partnership with the University of Iowa and health care providers throughout the state, provides comprehensive genetics services. IDPH manages the five CCID programs with assistance from the Congenital and Inherited Disorders Advisory Committee (CIDAC). The five programs are the Iowa Neonatal Metabolic Screening Program (INMSP), the Expanded Maternal Serum Alpha-fetoprotein Screening Program (MSAFP), Regional Genetic Consultation Services (RGCS), the Neuromuscular and Related Disorders Program, and the Iowa Registry for Congenital and Inherited Disorders (IRCID). The INMSP, the RGCS, and the Neuromuscular and Related Genetic Disorders Program conduct statewide outreach clinics. Clinics offer diagnostic evaluation, confirmatory testing, medical management, education, case management, consultation and referral.

The IRCID mission is to maintain statewide surveillance for collecting information on birth defect occurrence in Iowa, monitor annual trends in birth defect occurrence and mortality, conduct research studies to identify genetic and environmental risk factors for birth defects and promote educational activities for the prevention of birth defects. In 2002, the IBDR developed a parental notification system that informs parents or guardians of children who are diagnosed with a birth defect and provide them with resource information. The parental notification system includes a resource brochure and a notification letter. The CCID works closely with the Early Hearing Detection Initiative to coordinate screenings for all newborns in the state.

In 2009, Iowa contracted with the North Dakota newborn screening program coordinator to implement a "regional" newborn screening coordinator position. This person is responsible for the coordination of both states' education, communication, and quality assurance efforts regarding the newborn metabolic screening programs. Iowa also secured another CDC funded grant to expand the existing birth defects registry to include confirmed newborn screening cases. The Early Hearing Detection and Intervention (EHDI) program is included in this project, and work is underway to build a data dictionary necessary for EHDI reporting, based upon the completed work that established the variables and data dictionary for the metabolic screening reporting.

Unintentional Injury Prevention
The BFH collaborates with multiple partners to prevent unintentional injuries to children. Staff from the BFH participate in the IDPH Statewide Injury Prevention Advisory Council and the IDPH Healthy Homes Initiative. The BFH works with the Governor's Traffic Safety Bureau (GTSB) to identify strategies for information dissemination. Local MCH agencies are able to request free educational materials from the GTSB to share with clients, particularly regarding child passenger safety.

Healthy Child Care Iowa (HCCI) works through local and regional Child Care Nurse Consultants to provide onsite injury prevention assessments of early care, health, and education providers at no cost to the provider. CCNC's are employed by or under contract with local CH agencies. Assessments utilize U. S. Consumer Product Safety Commission recall notices, safety notices and guidelines to look for hazardous and recalled equipment, inclusion of high risk or age inappropriate practices, handling and storage of hazardous substances and site specific hazards.

Early ACCESS
Early ACCESS is a federal program under the Individuals with Disabilities Education Act (IDEA, Part C). In Iowa, the program is an interagency collaboration among the Departments of Education, Public Health, Human Services and Child Health Specialty Clinics. The system is a partnership between families with young children ages 0 to 3 and providers from the agencies listed above. The purpose of Early ACCESS is to identify, coordinate and provide needed services and resources that will help families assist their infant or toddler to grow and develop. The Iowa Department of Education (DE) is the lead agency, as appointed by the Governor for the implementation and maintenance of the system. A state level multidisciplinary council, the Council for Early ACCESS advises and assists the DE in the implementation of Early ACCESS.

Signatory partners collaborate with the DE to address the needs of children ages 0-3 with developmental delays or the risk of delay and their families. Child Health Specialty Clinics provides service coordination to medically fragile and drug exposed children, as well as provides nutrition services of all children enrolled in Early ACCESS that require nutrition services. IDPH provides service coordination to children who are lead poisoned.

Federally Qualified Health Centers
Iowa currently has 14 FQHCs: Community Health Care in Davenport, Community Health Center of Fort Dodge, Inc., Community Health Centers of Southeastern Iowa in Columbus Junction, Community Health Centers of Southern Iowa in Leon, Lamoni, Chariton, Centerville, and Albia, Council Bluffs Community Health Center, Crescent Community Health Center in Dubuque, Des Moines Health Center in Des Moines, Greater Sioux Community Health Center in Sioux Center, Peoples Community Health Clinic in Clarksville, Primary Health Care, Inc. in Des Moines and Marshalltown, River Hills Community Health Center in Ottumwa, Siouxland Community Health Center in Sioux City and United Community Health Center Inc. in Storm Lake.

Primary Care Association
The IDPH has a long-standing relationship with the Iowa/Nebraska Primary Care Association (IA/NEPCA). The Association provides technical and non-financial assistance to the community and migrant health centers of Iowa and Nebraska. These health centers offer comprehensive, physician-based "one-stop" primary care with a focus on prevention. The seven community health centers in Iowa are IA/NEPCA members. The Association works closely with the state departments of health in Iowa and Nebraska, along with the Federal Bureau of Primary Health Care, and participates in collaborative activities promoting quality health care services.

Child Health Specialty Clinics
The Child Health Specialty Clinics (CHSC) administrative offices are located at the University of Iowa in Iowa City. Proximity to a major university health center provides a source of pediatric and public health expertise that is shared with CHSC's statewide staff and collaborating agencies. Continuing education programming occurs on-site in Iowa City, at community locations, over the statewide fiberoptic communication network, and via internet webcam connections. Health professionals and public health students -graduate and undergraduate -learn about community-based service delivery through participation in direct care specialty clinics, care coordination services, family support and infrastructure building activities. CHSC's relationship with the University provides information technology resources, financial management services, public policy expertise, and research design and program evaluation consultation.

CHSC maintains interagency agreements with state entities. The following list indicates the agencies with which CHSC maintains agreements and summarizes the purpose of each agreement. CHSC has formal agreements with:

1) IDPH, BFH -to promote development of a cooperative and collaborative relationship at state and local levels through cross-referrals, sharing of staff, coordinating staff training, and interfacing data systems;
2) IDPH, BFH -to provide public health services at the community level including Child Health, Child Dental Health, and hawk-i Outreach. These contracts will expire September 30, 2010.
3) IDPH to provide medical consultation to the Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health.
4) IDPH to provide community-based clinical consultation and care planning recommendations for children and youth with any combination of special needs. Provide core public health functions of assessment, policy development and assurance as applicable to system development and quality improvement for children and you with special health care needs.
5) IDPH to provide a mechanism for sharing information to facilitate child find, follow-up, and quality assurance to further develop and enhance a quality EHDI surveillance system. Follow-up with families to ensure all children are screened and offered family support services is the primary

focus.
6) Area Education Agencies, using American Reinvestment Recovery Act (ARRA) funds, to provide service coordination and/or nutrition services, as defined in Iowa's IDEA rules and regulations, through a family-centered process to infants and toddlers and their families when eligibility is based on a health or medical condition;
7) Iowa Department of Human Services (DHS) -to define responsibilities of the parties in assessment, planning, and care coordination activities for children with special health care needs who are recipients of the EPSDT Program of Title XIX (Iowa Medical Assistance Program) and applicants and recipients of the consolidated Waiver Programs of Title XIX.
8) DHS/Mental Health Disability Services -- To support families of children with developmental disabilities n accessing services and supports by building and operating the Family Support 360-Iowa Navigation Network (Family 360-INN), a key component in the development of a family-driven statewide system of care for children in Iowa.
9) DHS -- Funding through SAMHSA, Northeast Iowa Children's Mental Health Initiative. Develop and provide family-centered and community-based services for children with Severe Emotional Disturbances-children with mental behavioral health care needs in a 10 county area.
10) Iowa Department of Education (DE) -- Through ARRA funds, provide specific deliverables that will benefit infants and toddlers ages 0-3 years, e.g. white paper re social determinants of health; white paper re exposure to environmental toxins; nutrition services delivered in natural environments; quality improvement for Iowa's system of care for premature infants; promotion of early literacy through Reach Out and Read; training for professional working with children with autism spectrum disorder; service coordination for children in foster care, etc.
11) DE -to delineate roles and responsibilities and provide technical assistance in the implementation of Early ACCESS (Part C, IDEA) including coordination and non duplication of services. To provide Early ACCESS service coordination and nutrition services for infants and toddlers who are born prematurely, drug-exposed, or medically fragile that contribute to a coordinated, statewide system of family-centered early intervention services.
12) DE to provide consultative technical assistance and staff development in the area of Autism disorders to state and local agencies serving children and youth with Autism.

F. Health Systems Capacity Indicators

Introduction

This section describes what has influenced Iowa's Title V program's ability to maintain and/or improve the Health Systems Capacity Indicators as well as what efforts are being made by the program in developing new strategies for meeting the HSCIs. This section also includes interpretation of the data and what that may indicate for the program.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	48.4	42.7	42.9	28.1	36.0
Numerator	875	820	841	565	734
Denominator	180755	192055	195916	201321	203997
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2009
The 2009 data were obtained from the Iowa Hospital Association.

Notes - 2008
The 2008 data were obtained from the Iowa Hospital Association.

Notes - 2007
The 2007 data were obtained from the Iowa Hospital Association.

Narrative:
in 2009 the Iowa Department of Public Health applied for the competitive application for the Asthma Control Program from CDC and was not awarded the grant. No entity in Iowa was awarded a grant. IDPH had minimal funds left over from 2008 and used through funds to establish a contract with the American Lung Association of Iowa to operate the Iowa Asthma Coalition and finalize Iowa's state plan- A Plan to Improve the Health of Iowans with Asthma 2010-2015.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	94.6	95.5	88.3	87.9	89.3
Numerator	17636	18498	17841	17575	18056
Denominator	18639	19379	20200	20001	20225
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The 2009 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2008
2008 Data were obtained from the CMS 4.16 Annual EPSDT Participation Report. Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.
Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Narrative:
Iowa's Title V program contracts with 22 local community-based agencies for the Child Health program covering each of Iowa's 99 counties. A primary focus of the child health program is to

assure that children served receive the well child screening services that they are eligible for according to guidelines established in the Iowa Recommendations for Scheduling Care for Kids Screenings (EPSDT Periodicity Schedule). Local contract agencies provide care coordination services to link children to medical homes for the well child screening services. Based upon a local needs assessment, child health contractors may provide selected gap-filling direct care services, and a few continue to provide the full well child screen.

The Bureau of Family Health has established an intergovernmental agreement with the Iowa Department of Human Services. Under this agreement, local child health contract agencies are approved as Medicaid Screening Centers. Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the child's Medicaid coverage and the importance of well child services. Care coordinators also contact the family when the child is due for well child screens according to the Iowa Recommendations for Scheduling Care for Kids Screenings. The statewide toll-free Healthy Families Line also links families with an EPSDT care coordinator for assistance with access to medical care. Care coordinators are encouraged to partner with local physicians to ensure that children receive their regular well child exams. The report for HSCI #02 appears on Form 17.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	15	9	9	8	20
Denominator	15	9	9	8	20
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from hawk-i 2009 data

Notes - 2008
2008 Data were obtained from hawk-i data.

Notes - 2007
Data were obtained from hawk-i 2007 data. The small number is due to financial eligibility at 185 percent poverty level. Most infants who qualify for public health insurance qualify for Medicaid.

Narrative:
During 2008, the income eligibility guidelines for both Medicaid and hawk-i were 200% of FPL for infants 0 to1. Both Iowa's hawk-i and Medicaid programs did allow for a 20% disregard for earned income. Only a very small number of infants were enrolled in hawk-i due to Federal CHIP policies requiring that any child who applies for hawk-i but is eligible for Medicaid, be enrolled in Medicaid. During the 2008 legislative session, SF 389 was passed and signed by the Governor which effectively raised eligibility to 300% of FPL for infants in both Medicaid and hawk-i starting July 1, 2009. Beginning July 1, 2009, the hawk-i program no longer uses the 20% earned income

disregard, while the Medicaid program continues to use it. This means that more infants in families with earned income may be eligible for Medicaid. However, due to some differences in how Medicaid and hawk-i count certain types of income, situations will continue to exist where, based on how Medicaid counts income, family income exceeds 300% of FPL but, based on how hawk-i counts income, family income does not exceed 300% of FPL. So, infants will continue to be enrolled in the hawk-i program when Medicaid ineligibility exists.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	75.2	82.8	74.0	74.4	74.4
Numerator	29336	32539	29602	29431	29270
Denominator	39014	39275	40000	39573	39367
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Iowa implemented a revised birth certificate during this reporting period. The questions about entry into prenatal care was changed. Data staff are investigating the accuracy of the reporting. Data were obtained from 2007 Vital Statistics data.

Narrative:
Direct health care, enabling, and population-based program activities are provided by 24 local maternal health grantee agencies serving all 99 counties in Iowa. Maternal health grantee agencies provide services to facilitate early entry into prenatal care. These services include Medicaid presumptive eligibility determination, care coordination, case management including follow-up, and case-finding and outreach with a focus on high-risk women. The IDPH works with the Iowa Department of Human Services (DHS) to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

Local MH contract agencies continue to use the Women's Health Information System (WHIS) to document assessment and services for the Title V maternal health population. WHIS provides information on the timing and number of prenatal visits as well as the newborn's gestational age. IDPH is opening up the WHIS data system for an upgrade to incorporate the updated Medicaid Risk Assessment from the Iowa Department of Human Services. The WHIS upgrade will also add service documentation features to comply with recently revised Medicaid documentation requirements. The report for HSCI #04 appears on Form 17.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	63.6	64.9	44.1	45.0	47.7
Numerator	151992	159473	109659	114749	132393
Denominator	239068	245785	248599	255061	277541
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The 2009 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2008
2008 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.
Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Narrative:
As previously noted in HSCI #2, Iowa's Title V program contracts with 22 local agencies for the Child Health program covering each of Iowa's 99 counties. A primary focus of the child health program is to assure that children served receive the well child screening services that they are eligible for according to guidelines established in the Iowa Recommendations for Scheduling Care for Kids Screenings (EPSDT Periodicity Schedule). Local contract agencies provide care coordination services to link children to medical homes for the well child screening services. Based upon a local needs assessment, child health contractors may provide selected gap-filling direct care services, and a few continue to provide the full well child screen.

The Bureau of Family Health has established an intergovernmental agreement with the Iowa Department of Human Services. Under this agreement, local child health contract agencies are approved as Medicaid Screening Centers. Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the child's Medicaid coverage and the importance of well child services. Care coordinators also contact the family when the child is due for well child screens according to the Iowa Recommendations for Scheduling Care for Kids Screenings. The statewide toll-free Healthy Families Line also links families with an EPSDT care coordinator for assistance with access to medical care. Care coordinators are encouraged to partner with local physicians to ensure that children receive their regular well child exams. The report for HSCI #07A appears on Form 17.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	52.8	53.7	54.3	55.5	59.8
Numerator	24390	25768	26494	27647	32404
Denominator	46216	47985	48795	49855	54165
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The 2009 data were obtained from the CMS 4.16 Annual EPSDT Participation Report

Notes - 2008
2008 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Narrative:
The I-Smile Program was developed to fulfill a legislative directive to assure a dental home for Medicaid-enrolled children. The program emphasizes early intervention, prevention, and family-centered assistance. Primary strategies of the I-Smile Program were implemented in the Title V grantee agencies throughout Iowa and fully integrated with the local EPSDT programs. The IDPH dental director works with Community Health Center dental providers, emphasizing integrating their services within local public health and involvement in community-based health planning.

The IDPH Oral Health Bureau provides contracted funding to seven local child health agencies for the provision of school-based dental sealant programs during FFY10. The programs provide dental screenings and/or examinations and dental sealants to low-income, uninsured, and/or underinsured children in school-based settings. EPSDT care coordinators work with children identified with untreated decay or no source of regular dental care to assist them in accessing follow-up care from local dentists. The report on HSCI #07B appears on Form 17.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	91.9	91.7	0.0	0.0	0.0
Numerator	1175	1058	0	0	0
Denominator	1278	1154	1150	1150	7000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator value is a rough estimate based on www.SSA.gov, SSI Recipients by State and County.

Notes - 2008
The Social Security Administration's (SSA) information disclosure rules and regulations continue to be under review during this reporting year. Therefore, CHSC continues to NOT receive information regarding SSI-enrollees in Iowa. In June 2009, CHSC received notice from the SSA regarding readiness to negotiate a new memorandum of agreement (or data exchange permit) to share SSI enrollment information. We expect discussions to resume later in ffy'09 or early ffy'10 resulting in a new information sharing agreement.

The denominator value is a rough estimate based on prior years when SSA shared beneficiary information.

Notes - 2007
The Iowa Title V CSHCN Program is unable to supply data for HSCI #8 because of an SSA-initiated interruption in the sharing of data regarding children < 16 years old enrolled in the SSI Program. There are apparently confidentiality-related questions that have remained unresolved since early calendar year 2007. If and when sharing of SSI enrollement data with CHSC resumes, CHSC will, in turn, resume contacting families of SSI-enrolled children to offer assistance connecting children and families to needed rehabilitative services.

Denominator value is a rough estimate based on prior years when SSA shared beneficiary information.

Narrative:
Our Iowa Title V definition of rehabilitative services includes a detailed discussion with each family of a child determined eligible for SSI. The discussion is offered to eligible families who are served by CHSC's Ill and Handicapped Waiver Program (IHWP). Annually IHWP serves approximately 1800 children and youth less than 16 years of age. The discussions reiterate the beneficiary's eligibility and encourages application for Medicaid, as well as describe additional Title V CYSHCN services that may be useful or of interest. The Title V CYSHCN Program realizes that SSI eligibility discussions with families to request assistance from Title V is not precisely the same as providing "rehabilitative services." We do, however, believe that the discussion does offer a potential connection between SSI beneficiary families and Title V services. Discussions occur with approximately 90% of families served by IHWP under age 16 who are approved for SSI. The reason discussions do not occur with 100% of families is because a relatively small percentage of SSI-approved children reside in foster homes or other out-of-home placements and are in regular and close contact with Iowa's Department of Human Services (DHS). For those children, DHS is the logical and more effective resource regarding rehabilitative services. For the large majority of SSI-approved children that are not in foster care or other out-of-home placement, CHSC reminds families to apply for Medicaid services. Medicaid eligibility is automatic, but enrollment is not, so application is necessary. CHSC staff also provide other information regarding access to direct health care services, care coordination, and financing. Families are encouraged to contact the CHSC regional office nearest them if they feel CHSC might be of assistance. This would then begin a more formal service relationship between the SSI-approved child, their family, and the State Title V CYSHCN Program. In FFY07, problems with interagency sharing of SSI Program enrollment data prevented CHSC from distributing information letters to families. CHSC has requested assistance from the Disability Determination Services in Iowa to potentially disseminate written communication to families. The request is under review by the Center for Disability Programs in Kansas City.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2009	matching data files	6.5	6.7	6.6

Narrative:
The Medicaid claims file/birth certificate linked file for calendar year (CY) 2009 was used to calculate the percent of Iowa infants born with LBW. The proportion of LBW infants born to Iowa mothers overall was 6.6% overall. The proportion of infants born with LBW has changed little during CY 2007, 2008, and 2009; specifically, the year by year differences were not statistically significant. Likewise although the proportion of infants born with LBW has fluctuated among women by year and by Medicaid status, the differences by year were not statistically significant. However, it is important to note that although Medicaid recipients access prenatal care later than non-Medicaid recipients and were less likely to receive adequate PNC, the proportion difference in LWB by Medicaid status was not statistically significant. In other words it was essentially equal. We are in the process of conducting data analyses using Iowa PRAMS data from CY 2007 and 2008. These data may provide more insight into the factors that contribute to LBW and insight into strategies to significantly reduce infant LBW. In response to the high proportion of Medicaid women who reported that they smoked during pregnancy, beginning in January 2008, Medicaid implemented coverage for a smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits. Strategies are being implemented to increase recipients' knowledge and awareness of the smoking "Quit-line". Evaluation of the effectiveness of the new Medicaid benefit was initiated with the 2007 birth cohort. To date, it appears that the uptake of smoking cessation medication during pregnancy has been low. We are assessing why this is the case.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2009	matching data files	4.6	3.3	3.8

Narrative:
The Medicaid claims file/birth certificate linked file for calendar year (CY) 2009 was used to calculate the Infant Mortality Rate (IMR) for Iowa infants. The overall IMR continues to decrease. The overall number of infant deaths dropped to 152 in CY 2009 from 219 in CY 2007 and 210 in CY 2008. This decrease in infant deaths from 2007 to 2009 seems unlikely and the Department is assessing the possibility of unreported infant deaths. Nonetheless, the decrease number of infant deaths has resulted in a lower infant mortality rate overall and by Medicaid status as indicated in the table above.

IDPH will use new data sources to enhance understanding of appropriate intervention strategies. Further IPRAMS analysis and the future project PPOR planned for FFY 1011 will assist Iowa's maternal health system to use evidence-based practices to identify gaps in community resources and define disparities.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	matching data files	63.6	80.2	73.7

Notes - 2011
The data for percent of infants born to pregnant women receiving prenatal care beginning in the first trimester were obtained from 2008 data, not 2009 data which used as the NPM data source

Narrative:
The Medicaid claims file/birth certificate linked file for calendar year (CY) 2009 was used to examine the proportion of women who initiated prenatal care (PNC) in the first trimester. The overall proportion of Iowa mothers who initiated PNC in their first trimester increased slightly when comparing CY 2008 to 2009. This increase though small, was statistically significant. In addition, the result may not be clinically significant given the large numbers used to calculate the result decreased by 15 percent for CY 2007 compared to CY 2006. The gap between first trimester initiation of PNC between Medicaid and non-Medicaid women remains at approximately 16% for CY 2008.
Local maternal health contract agencies provide presumptive eligibility. Local agency activities involved in increasing the number of women who enter prenatal care in the first trimester include a public awareness campaign; outreach presentations to churches, schools, and community centers; flyers distribution to pregnant women; WIC and MCH staff providing follow-up contacts; and school nurses providing information on the MH programs encouraging education on early prenatal care. In FFY2010, several agencies plan to offer free pregnancy tests to improve early identification of adolescent pregnancies. This information is shared with local school nurses to help increase awareness and referrals for pregnancy testing and prenatal care.

The report for HSCI #05C appears on Form 18.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	matching data files	75.5	86	81.8

Notes - 2011
Data were obtained from 2008 Vital Statistics. A program written by NCHS was used to calculate these results.

Narrative:
The Medicaid claims file/birth certificate linked file for calendar year (CY) 2008 was used to calculate the Kotelchuck index for Iowa mothers. Overall 81.8% of Iowa mothers received adequate PNC in CY 2009 compared to 79.7% in 2008. The slight increase in adequate PNC is statistically significant, though may not be clinically significant given the large numbers used to calculate the result. Eight-six percent (86.0%) of non-Medicaid women received adequate prenatal care. The proportion of Medicaid mothers who received adequate prenatal care was 75.5% , more than ten percent lower than non-Medicaid mothers.

As discussed in the HSCI #4 narrative, local maternal health agencies use the Women's Health Information System (WHIS) to document assessment and services for the Title V maternal health population. WHIS provides information on the timing and number of prenatal visits as well as the newborn's gestational age. Software upgrades are expected to support incorporation of the updated Medicaid Risk Assessment from the Iowa Department of Human Services.

The report for HSCI #05D appears on Form 18.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	300

Notes - 2011
2009 data obtained from Medicaid/SCHIP eligibility data.

Narrative:
During the 2008 legislative session, SF 389 was passed and signed by the Governor which effectively raised eligibility for Medicaid to 300% FPL for infants in Iowa effective July 1, 2009. Infants are no longer enrolled in hawk-i because they are now eligible for Medicaid; this increase

in the percent of poverty level eliminated the inconsistencies between Medicaid and hawk-i programs' income eligibility requirements for infants.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	300

Notes - 2011
2009 data obtained from Medicaid/SCHIP eligibility data.

Narrative:
With the passage of SF 389, the income guidelines for hawk-i were raised to 300% FPL effective July 1, 2009.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	300

Notes - 2011
2009 data obtained from Medicaid/SCHIP eligibility data.

Narrative:
To align the Medicaid and hawk-i programs' income requirements, SF 389 directed Medicaid to provide coverage to pregnant women whose family income is at or below 300% FPL.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR	**Does your MCH program have**	**Does your MCH program**

SURVEYS	the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Iowa's State Systems Development Initiative (SSDI) devotes its resources to ensuring that MCH program partners have access to policy and program relevant information. The development and implementation of the 2010 Iowa Child and Family Household Health Survey (HHS) is a priority SSDI initiative. The survey is a population-based statewide household telephone survey. The survey process begins with a screening question to determine if the residence is home to a family with children. If so, the adult most knowledgeable about the health and health care of a randomly selected child under age 18 in the household is asked to complete the interview.

The 2010 HHS will be the third in a series of population-based Iowa surveys on children's health. Previous surveys have provided important program-relevant data for local and statewide MCH agencies and valuable information for the Title V Five Year Needs Assessment. Five reports containing analyses of the 2005 HHS are posted on the Internet at http://ppc.uiowa.edu/pages.php?id=31. The five reports address comprehensive statewide results, early childhood results, children's health insurance, nutrition and physical activity, and racial and ethnic disparities.

IDPH obtained a grant from the March of Dimes to implement a PRAMS-like pilot project. The $10,000 grant funded a survey of several hundred new mothers four months after delivery and provided an understanding of the new mothers' post-partum behavior. The survey provided

insights into possible relationships between lifestyles before birth and poor pregnancy outcomes, such as low birth-weight infants. The survey was called the Iowa Pregnancy Risk Assessment Monitoring System (I-PRAMS). With this experience made possible with March of Dimes funding, IDPH hopes to compete successfully during the next round of national PRAMS funding opportunities.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No
Iowa Youth Survey	2	No
Iowa Youth Tobacco Survey	3	Yes

Notes - 2011

Narrative:
In Iowa, The YRBSS is conducted by the Department of Education every two years in the odd numbered years. Participation in the YRBSS is hindered by the administration of the Iowa Youth Survey (IYS) every three years. Schools are more apt to participate in the IYS than the YRBSS because they get local education agency data from the IYS. Iowa is moving toward administering the IYS every two years in the even numbered years to avoid this conflict and increase the participation in the YRBSS.

The Iowa Youth Tobacco Survey (IYTS) is conducted every two years. It is a comprehensive survey of tobacco use, secondhand smoke exposure, access, cessation, tobacco-related attitudes, tobacco marketing and tobacco prevention exposure and awareness of the JEL campaign among Iowa youth. The IDPH Division of Tobacco Use Prevention and Control conducts the IYTS to measure the effectiveness of youth tobacco-use prevention and cessation programs within Iowa. The IYTS results indicate that tobacco-use prevention efforts in Iowa have been successful.

Since 2000, there has been a dramatic decrease in the prevalence of tobacco use by youth in Iowa. In middle school between 2000 and 2008, cigarette smoking dropped from 12% to just 3% (a decrease of 76%). In high school during those eight years, cigarette smoking dropped from 33% to 20% (a decline of 40%). The rate of smokeless tobacco use has also decreased, falling to 1% among middle school students (down 75%) and to 9% among high school students (down 18%). Overall, tobacco use in all forms declined 31% among high school and 80% among middle school youth during this time.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The five-year plan for 2011-2015 places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a rural state with substantial shortages of medical services and maldistribution of existing services, Iowa is challenged to develop systematic approaches to population-based direct care services. In the past few years, program activities addressed improvement of access to services, identification of the needs of culturally diverse groups and recognition of changes brought about by managed care. Additionally, activities for children and youth with special health care needs focus on assuring specialty services to children and families, integrating data systems, balancing private and public partnerships and integrating community-based services. The Title V CSHCN program continues to regularly discuss and debate how best to proportion its resources among the four service levels of the MCH pyramid. This exercise has served to help keep lively the broad expectations and potential influences of the CSHCN program.

B. State Priorities

Problem Statements

1. Need Statement: Lack of adoption of quality improvement methods within maternal and child health practice

Performance Measure: The degree to which Iowa's state MCH Title V Program improves the system of care measured through the MCH Title V Index.

The primary purpose of children's health care is to help children grow and develop. Well-child care encompasses health supervision, developmental surveillance and screening, psychosocial assessment, immunizations and care coordination. However, there is clear evidence that the quality of children's preventive care is lacking. One-quarter of families felt they were not always treated with respect. Only half (46 percent) of parents of young children in Iowa reported remembering having received preventive counseling about subjects such as seatbelts and nutrition. Only 31 percent of children ages 0-3 in foster care receive Early ACCESS services.

2. Need Statement: Lack of a statewide coordinated system of care for children and youth with special health care needs

Performance Measure: The degree to which components of a coordinated statewide system of care for CYSHCN are implemented.

A recent review of MCH literature revealed that "CYSHCN are at a greater risk for unmet health care needs, poorer dental health, and behavioral problems. Expenditures for their care are approximately three times higher than for other children, accounting for approximately 42% of all medical care costs for children." (Kogan MD, Strickland BB, Newacheck PW. Building Systems of Care: Finding from the National Survey of CSHCN, Pediatrics 124:S4, S333-S336, December 2009. "A comprehensive community-based system of services for CYSHCN has not yet been implemented. Moreover, to our knowledge, there has been no consensus to date on what constitutes a system of services. The absence of a broadly accepted definition has hindered progress in implementation of a systematic approach to delivering services." Perrin JM, Romm D, Bloom S, Homer C et al, "A Family-Centered, Community-Based System of Services for Children and Youth with Special Health Care Needs. Arch Pediatr Adolesc Med/Vol 161 (No 10, October 2007).

3. Need Statement: Lack of health equity in maternal and child health outcomes

Performance Measure: The degree to which Iowa's state MCH Title V program addresses health equity in MCH programs measured through the MCH Title V index.

Disparities related to lack of health care access or prevention services are associated with higher morbidity and mortality rates among racial minorities. Addressing health differences involves understanding social and economic circumstances experienced by minority families. Social determinants of health include job and food insecurity, inadequate housing and poor family environments. Barriers to care such as cost, lack of transportation, limited hourly access, lack of information about the system and language difficulties also contribute to disparities. African-American children were most likely to be in a household with high parenting stress and most likely to not weigh the right amount for their height. Hispanic children of families taking the survey in Spanish had the lowest overall health and were the least likely to be insured. African-Americans have nearly twice the occurrence of low birth weight babies compared to whites. 36 percent of African-American women were 10 or more pounds overweight a year after delivery, compared to only 29 percent of Whites.

4. Need Statement: Lack of coordinated systems of care for preconception and interconceptioncare for high-risk and low income women

Performance Measure: Percent of women who are counseled about developing a reproductive life plan.

According to the 2000 US Census, Iowa has 353,129 women of childbearing age (15-44 years). Nationally, nearly half of pregnancies are unintended. Further, critical organ development begins just 17 days after conception, often before prenatal care has started. Preconception care encourages mothers to take folic acid daily to prevent spinal cord defects, adopting healthy lifestyle habits like avoidance of alcohol, tobacco cessation, and a nutritious diet and get information about the importance of prenatal care.Adequate prenatal care was received by 83.1 percent of pregnant women, including 77.5 percent on Medicaid. 6.7 percent of babies born are considered low birth weight (<2,500 grams). The birth rate for 15-17 year olds is 15.6 per 1,000.

5. Need Statement: Barriers to access to health care including mental health services for low-income pregnant women

Performance Measure: The degree to which the health care system implements evidence-based prenatal and perinatalcare.

According to the 2000 US Census, Iowa has 353,129 women of childbearing age (15-44 years). Nationally, nearly half of pregnancies are unintended. Further, critical organ development begins just 17 days after conception, often before prenatal care has started. Preconception care encourages mothers to take folic acid daily to prevent spinal cord defects, adopting healthy lifestyle habits like avoidance of alcohol, tobacco cessation, and a nutritious diet and get information about the importance of prenatal care.Adequate prenatal care was received by 83.1 percent of pregnant women, including 77.5 percent on Medicaid. 6.7 percent of babies born are considered low birth weight (<2,500 grams). The birth rate for 15-17 year olds is 15.6 per 1,000.

6. Need Statement:Lack of access to preventive and restorative dental care for low-income pregnant women

Performance Measure: Percent of Medicaid enrolled women receiving preventive dental health services during pregnancy.

A woman's oral health impacts pregnancy outcomes as well as the oral health of her infant. Diet and hormonal changes during pregnancy may increase a woman's risk for developing tooth decay and gum disease. Bacteria associated gum disease can spread to the body, triggering

premature labor. Women who participate in Medicaid are significantly less likely to visit the dentist before, during and after pregnancy, compared to those with private insurance. Bacteria that cause cavities can pass from a mother's mouth to her baby's mouth, increasing the risk of cavities for that infant. Children whose mothers have poor oral health are five times more likely to have oral health problems than children whose mothers have good oral health. In Iowa, although there have been marginal gains in the past few years, less than one in four Medicaid-enrolled women received important preventive dental care in 2007.

7. Need Statement: Insufficient early and regular preventive and restorative dental care for children ages 5 and under

Performance Measure: Percent of Medicaid enrolled children 0-5 who receive a dental service.

Children need healthy teeth to eat food to nourish their bodies, speak properly, and build confidence. Cavities can develop as soon as teeth erupt (at around 6 months old) and can limit children's ability to eat and thrive, as well as their ability to concentrate and learn. Cavities can be prevented, but not enough children receive early preventive care.Children's oral health is addressed through the I-Smile™ dental home initiative. Fifty- five percent of Medicaid-enrolled children ages 1-5 do not receive dental services. In 2008, 99.6 percent of Medicaid-enrolled children did not receive an exam from a dentist prior to the age of one. The ADA recommends children have a dental exam by their first birthday. Forty-nine percent Iowa's general dentists always refer children younger than 3 to pediatric practices --there are 39 private-practice pediatric dentists in the state. Twenty-two percent of Iowa third graders have untreated decay, an increase from 13 percent in 2006.6

8. Need Statement: High proportion of children ages 14 and under experiencing unintentional injuries

Performance Measure: Rate of hospitalizations due to unintentional injuries among children ages 0-14.

Injuries are a major public health concern in Iowa due to the large number of Iowans affected by them. Unintentional injuries are one of the leading causes of death for youth. Injuries can have long-term effects on quality of life due to physical impairment, memory troubles, emotional difficulties or learning disabilities and loss of ability to perform daily activities. Over 56,715 unintentional injuries occurred in children ages 14 years and under. Motor vehicle crashes accounted for the deaths of 4.6 children per 100,000. Five percent of children ages 0-5 had an injury requiring medical attention within the past year. From 1995-2007, 112 Iowa children under age 7 were victims of fatal child abuse with 49 percent of those dying from being shaken or slammed.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99.8	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	44	58	184	73	95
Denominator	44	58	184	73	95

Data Source				CCID and INMSP	CCID and INMSP
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
FFY09 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

Notes - 2008
FFY08 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

Notes - 2007
FFY07 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

a. Last Year's Accomplishments
The FFY09 performance objective of 100 percent was met. Data provided to the Center for Congenital and Inherited Disorders (CCID) and the Iowa Neonatal Metabolic Screening Program (INMSP) indicate that 100 percent of all eligible Iowa newborns that screen positive receive short-term follow-up through to confirmatory diagnosis, and long-term follow-up for clinical case management and treatment.

POPULATION-BASED SERVICES
The INMSP is a fee-for-service program that provides laboratory, follow-up, consultative and educational services. Responsibility for the Neonatal Metabolic Screening testing is assigned to the University Hygienic Laboratory at the University of Iowa. The U of I Newborn Metabolic Screening program staff provides follow-up on positive screens. All newborns are screened for medium chain acyl Co-A dehydrogenase deficiency, phenylketonuria, and other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry; hypothyroidism; galactosemia; hemoglobinopathies; congenital adrenal hyperplasia; biotinidase deficiency; and cystic fibrosis.

INFRASTRUCTURE BUILDING SERVICES
A HRSA-MCHB grant awarded to IDPH provides support for the Iowa Family Participation Project (IFPP). The IFPP aims to ascertain the awareness and perceptions of community members and primary care providers of the newborn screening programs in Iowa. The main goal is to increase parent participation in planning, implementing and evaluating the newborn screening programs.

IFPP staff conducted workgroup sessions with representatives of communities including Amish, Sudanese immigrants, chiropractic college affiliates, adoptive/foster parents and parents of children with a positive newborn screening result (false positive and true positive).
The IFPP has conducted an analysis of the workgroup sessions to date, and a summary of the comments and opinions received from these community members has been presented at numerous national meetings. A manuscript is being drafted for publication.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to allocate funds for the purchase of medical foods and metabolic formula.	X			
2. Promote development of data integration/linkages with birth certificate, laboratory, healthcare providers, and newborn hearing screening program.				X
3. Implement newborn screening surveillance program.				X
4. Continue to engage communities and healthcare providers in the planning, implementation and evaluation of newborn screening programs.		X		X
5. Monitor newborn metabolic follow-up program for referral patterns and linkages with medical home.				X
6. Evaluate conditions for addition to the universal newborn screening panel.			X	
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

The CCID is working with software programmers within the University Hygienic Laboratory (UHL) to explore the feasibility of integrating data analysis, such as screening rates, between the neonatal metabolic screening program and the newborn hearing screening programs.

CCID purchased proprietary data-matching software, and newborn screening staff and epidemiologists are currently receiving training on use of the program. The program, is being used to match birth records with screening records to assure every child born in Iowa has received newborn screening.

The IDPH CCID was awarded a grant from the Centers for Disease Control and Prevention (CDC) to expand the existing Iowa Registry for Congenital and Inherited Disorders (IRCID) to include confirmed newborn screening cases. Implementation has begun via case identification by the long-term follow-up programs, the UHL and Early Hearing Detection and Intervention (EHDI) programs.

A neonatal metabolic screening program regional coordinator has been hired, and provides coordination, education and quality assurance services to North Dakota and Iowa. The regional coordinator implemented a quality review process that examines cases of a "breach" in quality in a team format. Corrective action is documented, and the activity monitored for the expected improvement.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The CCID Executive Committee will convene to review the structure of congenital and inherited disorder programming in the state, discuss emerging issues and determine potential efficiencies and quality improvement through integration of newborn screening programs. An annual work plan will be drafted for 2011 that defines approaches to addressing emerging issues.

The CCID will analyze data from the newborn screening follow-up database to determine trends

in referral patterns and needs of communities for quality referral (subspecialty) medical care. Surveillance for confirmed hearing loss cases will be added to the Registry.

The INMSP will continue to explore funding to sustain the support for families who do not have funds to purchase medical foods or metabolic formula.

POPULATION-BASED SERVICES
The INMSP will investigate resources needed to add Severe Combined Immune Deficiency (SCID) to the newborn metabolic screening panel, as recommended by the Secretary's Advisory Committee on Heritable Diseases in Newborns and Children. Iowa will collaborate with Wisconsin on expansion of Wisconsin's SCID screening pilot project to include screening of Iowa newborns for SCID. New testing technologies will be compared with existing technologies used by Wisconsin.

ENABLING SERVICES
While funding for the Iowa Family Participation Project will end in 2010, family participation in the planning, implementation and evaluation of newborn screening programming will continue. A communication toolkit will be disseminated to health care providers and families to provide guidance for navigating the newborn screening process, and improve communication between families, providers and newborn screening staff.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**39570**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	39513	99.9	360	3	3	100.0
Congenital Hypothyroidism (Classical)	39513	99.9	300	5	5	100.0
Galactosemia (Classical)	39513	99.9	360	4	4	100.0
Sickle Cell Disease	39513	99.9	0	1	1	100.0
Biotinidase Deficiency	39513	99.9	360	3	3	100.0
Cystic Fibrosis	39513	99.9	0	14	14	100.0
21-Hydroxylase Deficient Congenital	39513	99.9	34	3	3	100.0

Adrenal Hyperplasia						
Fatty Oxidation Disorders	39513	99.9	360	4	4	100.0
Maternal Prenatal Screening	11076	28.0	159	0	0	
First Trimester Only	435	1.1	40	0	0	
Quad Screen	8732	22.1	385	0	0	
Integrated Screen	1732	4.4	58	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60.6	61.3	62	65.1	66.4
Annual Indicator	58.6	58.6	64.7	64.7	64.7
Numerator	225	225			
Denominator	384	384			
Data Source				NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	67.7	69.1	70.5	71.9	72

Notes - 2009
Annual indicator value is from '05-'06 NS-CSHCN. Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to partner in decision making.

Notes - 2008
Annual indicator value is from '05-'06 NS-CSHCN. Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to partner in decision making.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

The FFY09 performance target objective of 66.4 percent was not met. The indicator value for Iowa was 64.7 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 5th highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES
In FFY09, family participation program leadership was a standard participant in and contributor to all Title V CYSHCN Program strategic planning and high level decision-making.

CHSC family participation program leadership continued to recruit parent consultant network colleagues to formulate and influence public policy relevant to service systems for children with special health care needs.

Family involvement was a major strategy in the SAMHSA-supported System of Care development effort co-led by CHSC to improve services for children with severe emotional disorders. The System of Care has family involvement at every level including 52 percent parent membership on the CCC Governance Council as well as 47 percent parents of children with SED employed within the SAMHSA -funded System of Care.

In June 2009 CHSC received funds from HRSA to create a Family to Family Health Information Center (F2F HIC), a nonprofit, family-staffed organization to assist families of CYSCHN and the professionals who serve them by providing support, information, resources and training.

DIRECT AND ENABLING SERVICES
The family participation program in CHSC maintained a roster of parents of children with special health care needs working in seven program areas -- CHSC Clinical Services; Ill and Handicapped Waiver/Health and Disease Management; Part C service coordination; SAMHSA-supported Community Circle of Care; Early Hearing Detection and Intervention Guide by Your Side; Maternal and Child Health-Title V; and Autism Spectrum Disorder-ABA.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC will continue to implement the Family-to-Family Health Information Center grant. The F2F Governance Council will merge with the Family 360 Governance Council.				X
2. CHSC will pursue receiving technical assistance to fulfill the requirements to become a credentialed agency under the Iowa Family Support Standards.				X
3. CHSC will continue to subcontract with the Iowa Department of Human Services to implement components of the Iowa's Family 360 grant (awarded from US Dept of HHS-ACF).				X
4. Parent consultants will receive ongoing training to fulfill specific care coordination and family support functions within CHSC's system of care for children and youth with special health care needs.		X		
5. Family support in CHSC will continue to maintain a roster of parents of children with special health care needs working in eight program areas.		X		
6.				
7.				
8.				

9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

In FFY10, family participation by two CHSC parent consultants continues on the CHSC Leadership Council.

CHSC community-based parent consultants serve on multiple state level advisory groups.

The CHSC co-led SAMHSA-supported System of Care project adheres to "family-driven" and "youth-guided" principles and is developing parent certification standards via Magellan Behavioral Health. A new family organization for families of children with emotional and behavioral challenges has been formed, an incorporated branch of the National Federation of Families organization.

A CCC parent consultant was hired to build support services in rural northeast Iowa

CHSC applied to receive technical assistance to become a credentialed agency under the Iowa Family Support Standards, a state endorsed credentialing process for Iowa's in-home family support workers.

CHSC lead implementation of the Family to Family Health Information Center (F2F HIC).

CHSC subcontracted with the IDHS to begin implementation of Iowa's Family 360 grant (awarded from US Dept of HHS-ACF), staffed by parent consultants.

CHSC emphasized family participation in the 5-year Title V needs assessment activities.

DIRECT AND ENABLING SERVICES

CHSC's new vision statement identifies family support and care coordination as two of the four components of Iowa's system of care for CYSHCN.

The family participation program in CHSC maintained a roster of paid part-time parents of CYSHCN working in eight program areas

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

In FFY11, CHSC will continue to support and expand, as possible, CHSC's family participation across all levels of the MCH pyramid.

CHSC community-based parent consultants will continued to serve on multiple state level advisory groups: Medicaid's Medical Assistance Advisory Committee, Iowa Collaborative Safety Net Provider Network, Early ACCESS (Part C IDEA) Iowa Council on Early Intervention, Governor's Council for Prevention of Disabilities, University of Iowa Center for Disabilities and Development's Community Partnership Advisory Council, the University of Iowa Hospitals and Clinics' Family Advisory Committee, the Maternal and Child Health Advisory Council, and local and county governance boards to guide Community Circle of Care (CCC).

CHSC will continue to implement the Family-to-Family Health Information Center grant.

CHSC will continue to subcontract with the Iowa Department of Human Services to implement components of the Iowa's Family 360 grant (awarded from US Dept of HHS-ACF).

CHSC parent consultant staff will oversee Family to Family Iowa, the stakeholder decision-

making group for the merged F2F and F360 grant projects.

CHSC will continue to update CHSC's bank of family stories for use in program marketing and stakeholder education.

CHSC will assure standard skills and competencies of its parent consultants by receiving technical assistance to become a credentialed agency under the Iowa Family Support Standards, a state endorsed credentialing process for Iowa's in-home family support workers (if CHSC's application is successful.)

CHSC leaders will implement mechanisms to collect ongoing family satisfaction data.

DIRECT AND ENABLING SERVICES
Family support in CHSC will continue to maintain a roster of parents of children with special health care needs working in eight program areas -- CHSC Clinical Services; Ill and Handicapped Waiver/Health and Disease Management; Part C service coordination; SAMHSA-supported Community Circle of Care; Early Hearing Detection and Intervention Guide by Your Side; Maternal and Child Health-Title V; Autism Spectrum Disorder-ABA; and Family 360 Navigators.

Parent consultants will receive ongoing training to fulfill specific care coordination and family support functions within CHSC's system of care for children and youth with special health care needs.

A minimum of 15 additional family support workers from Iowa's family support groups will be trained in Family 360 Navigator skills and deliver family navigation services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60.6	61.8	63	60.3	61.5
Annual Indicator	57.1	57.1	57.4	57.4	57.4
Numerator	413	413			
Denominator	723	723			
Data Source				NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	62.7	64	65.3	66.6	

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as

motivation to remain involved in system development efforts designed to improve the medical home model.

Notes - 2008
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the medical home model.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Although, we did not meet the 2007 target, we are encouraged to set increasing target objectives based on the assumption that recent 2008 health care reform state legislation will have a strong positive influence on primary care providers to pursue a medical home model of care delivery.

a. Last Year's Accomplishments
The FFY09 performance target objective of 61.5 percent was not met. The indicator value for Iowa was 57.4 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 1st among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, the Iowa Medical Home Initiative continued two new partnerships with: 1) the Iowa Department of Public Health 1st Five project emphasizing improved early childhood developmental screening and referral practices by primary care providers; and 2) the Iowa-Nebraska Primary Care Association (IA/NEPCA) to facilitate investigation of medical home model practices by Iowa's safety net providers (e.g. free clinics, MCH agencies, and local boards of health).

CHSC completed the final phase of a contract with Early ACCESS (IDEA Part C) to support the Iowa Medical Home Initiative. A final report was submitted by the Iowa Child and Family Policy Center, which administered pre and post intervention data using the American Academy of Pediatrics survey instrument to gather information regarding practice-based early childhood screening and referral activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC created a 0.4 FTE Pediatric Clinical Consultant position to facilitate and oversee CHSC Clinical Services and develop standards for all aspects of CHSC's clinical care.				X
2. CHSC's Pediatric Clinical Consultant partnered with the Director of the Iowa-Nebraska Primary Care Association to develop strategies to advise safety net providers in becoming medical homes in order to fulfill the legislative mandate.				X
3. CHSC is implementing a new vision statement to assure a				X

system of care for cyshcn, and defined the system as containing two key components of a medical home: care coordination and family support.				
4. CHSC created a care coordination workgroup to develop, implement and evaluate standardized procedures for the delivery of care coordination to cyshcn within medical homes.				X
5. CHSC continues to participate in Early Childhood Iowa, a state level interagency systems and policy development group whose mission is to improve the system of early care, health and education of young children, including the goals that all have acce				X
6. CHSC is initiating a project with the National Improvement Partnership Network (NIPN) with supplemental funding from Part C IDEA economic stimulus funds, to assure NICU graduates receive high quality care within medical homes and neighborhoods.				X
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:
A Pediatric Clinical Consultant oversees all aspects of CHSC's clinical care. She is a member of the Iowa Medical Home Advisory Council and partners with the Director of the Iowa-Nebraska Primary Care Association to advise safety net providers in becoming medical homes.

CHSC's care coordination workgroup develops standardized procedures for care coordination within medical homes.

The IDPH led by the Medical Home System Advisory Council participated in the National Academy of State Health Policy's medical home consortium to advance development and spread of the medical home concept specifically for children in Medicaid and SCHIP.

Iowa's Early Hearing Detection and Intervention System of Care conducts quality improvement measures with primary care practices.

CHSC is initiating a project with the National Improvement Partnership Network to assure NICU graduates receive high quality care within medical homes and neighborhoods.

CHSC is implementing the electronic medical record system EPIC and the web-based electronic Individualized Family Services Plan for IDEA Part C, to improve provider/family/health neighborhood communication.

The SAMHSA supported System of Care for youth with SED connects youth to a local medical home once the youth is stabilized with care coordination and support services.

DIRECT AND ENABLING SERVICES
CHSC staff provide care coordination activities for CYSHCN in partnerships with primary care and health neighborhood providers.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:
In FFY11, The CHSC Pediatric Clinical Consultant will continue collaborations with the IDPH 1st Five Program and the Iowa-Nebraska Primary Care Association Safety Net Provider projects to fulfill any requested consultation on care coordination and the medical home model.

CHSC will make its expertise available and position itself as a potential partner for any state or regional efforts to spread the medical home model in accordance with the legislative requirements of Iowa's new health care reform statute.

Iowa Early Hearing Detection and Intervention System of Care will spread lessons learned from 2010 activities re medical homes, into other regions of the state.

CHSC will continue to spread the medical home model for benefit of young children as supported by Iowa's Early Childhood Initiative strategic plan and the Off to a Good Start Coalition.

CHSC will continue to participate in Early Childhood Iowa, a state level interagency systems and policy development group whose mission is to improve the system of early care, health and education of young children, including the goals that all have access to medical and dental homes.

CHSC strategic plans will promote, through the work of its care coordination workgroup, stronger, more effective connections between Iowa's primary care providers and community-based care coordination resources.

CHSC will continue to participate in NIPN to assure NICU graduates receive high quality care within medical homes and health neighborhoods.

CHSC will utilize data obtained from the 2010 Iowa Household Health Survey to evaluate the status of medical homes for CYSHCN in Iowa.

CHSC will explore case management components of its electronic medical record system, EPIC, and will assure all early intervention service coordinators use electronic IFSPs and enter health information, as well as service coordination information.

The SAMHSA supported System of Care for youth with SED will continue to connect youth to a local medical home once the youth is stabilized with care coordination and support services.

DIRECT AND ENABLING SERVICES
CHSC parent consultants, staff nurses, dietitians, social workers with the CCC program, and Advanced Registered Nurse Practitioners will continue to provide care coordination activities for CYSHCN in partnerships with primary care and health neighborhood providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67.7	71.1	74.7	72	73.4
Annual Indicator	64.5	64.5	68.6	68.6	68.6
Numerator	468	468			
Denominator	726	726			
Data Source				NSCSHCN	NSCSHCN

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	74.9	76.4	77.9	79.5	

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to have adequate public and/or public insurance.

Notes - 2008
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to have adequate public and/or public insurance.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Although we did not meet the 2007 target, we set increasing target objectives because of the consistently and broadly acknowledged high importance of this insurance-related outcome priority.

a. Last Year's Accomplishments
The FFY09 performance target objective of 73.4 percent was not met. The indicator value for Iowa was 68.6 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 4th highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

CHSC was a planning partner in a statewide early childhood advocacy effort - the "Off to a Good Start Coalition" - that promotes the health-related goals of Iowa's Early Childhood Comprehensive Systems project, one of which is to assure adequate health and dental insurance coverage. Iowa Legislature increased SCHIP coverage to 300% of poverty.

DIRECT AND ENABLING SERVICES
CHSC regional centers worked with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process. CHSC's Health & Disease Management unit provided guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC participates on the Iowa-Nebraska Primary Care Association Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.				X
2. The Iowa EHDI System of Care helped provide family stories and administrative support to educate Iowa legislations re the need to include hearing aid as part of covered expenses within private insurance plans for young children with hearing loss. Th				X
3. CHSC's care coordination work group is collecting data that will be used for discussions with Iowa Medicaid to illustrate the benefits of care coordination to cyshcn, to advocate for Medicaid policy that reimburses for care coordination.				X
4. CHSC regional centers work with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process.		X		
5. Parent Consultants are working with children with autism spectrum disorder to collection data on a CDC-research grant that seeks to demonstrate the benefits of Applied Behavioral Analysis. Data will be used to educate private and public insurers for		X		
6. CHSC regional centers work with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process.		X		
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

CHSC participates on the Iowa-Nebraska Primary Care Association Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

A CHSC parent consultant serves on a Governor-appointed Medicaid advisory committee.

CHSC is represented on Iowa's Early Childhood Comprehensive Systems project, which contains strategic goals to assure adequate health and dental insurance coverage.

CHSC's care coordination work group is collecting data that will be used for discussions with Iowa Medicaid to illustrate the benefits of care coordination to CYSHCN to advocate for Medicaid policy that reimburses for care coordination.

CHSC participated on a task force assembled by the Iowa Insurance Division to investigate improvement strategies in coverage for services to Iowa children with autism spectrum disorders.

DIRECT AND ENABLING SERVICES

CHSC regional centers work with families of CYSHCN to apply for Medicaid or SCHIP.

CHSC's Health & Disease Management unit continues to provide guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care

financing.

Parent Consultants are working with children with autism spectrum disorder to collect data on a CDC-research grant that seeks to demonstrate the benefits of Applied Behavioral Analysis. Data will be used to educate private and public insurers for potential policy changes.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING

In 2011, CHSC will participate, as requested, in any survey-based special reports (e.g. from the Iowa Child and Family Household Health Survey) on the insurance status of Iowa families.

CHSC will continue representation on the Iowa-Nebraska Primary Care Association Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

A CHSC parent consultant will continue participation on a Governor-appointed statewide Medicaid advisory committee.

CHSC care coordination work group will present data to Medicaid to advocate for payment for care coordination activities.

DIRECT AND ENABLING SERVICES

CHSC will continue to assist and enable families of children with special health care needs to apply for Medicaid or SCHIP.

CHSC's Health & Disease Management unit will continue to provide guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing.

CHSC Parent Consultants will continue to work with children with autism spectrum disorder to collect data for a NIMH-research grant that demonstrates the benefits of Applied Behavioral Analysis (ABA). Data will be used to educate private and public insurers for potential policy changes regarding reimbursement for ABA.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82.6	84.3	86	93.8	94.7
Annual Indicator	77.8	77.8	92.9	92.9	92.9
Numerator	301	301			
Denominator	387	387			
Data Source				NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95.6	96.6	97.6	98.6	

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve community-based service systems.

Notes - 2008
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve community-based service systems.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Although our data source for this NPM (the National CSHCN Survey) is only repeated every five years, we felt responsible to revise and raise the annual target objectives by a modest percentage as motivation to remain involved in system development efforts designed to improve families' easy use of community-based service systems.

a. Last Year's Accomplishments
The FFY09 performance target objective of 94.7 percent was not met. The indicator value for Iowa was 92.9 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 2nd highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES
In FFY09, CHSC state and regional staff participated in a SAMHSA-supported System of Care system improvement effort to develop a new, coordinated, family-driven system of care for children with severe emotional disorders. The newly formed System of Care is centered on providing a local, central point of coordination where families and youth can get the services they need, regardless of need or ability to pay.

CHSC staff supported the Iowa Department of Public Health's 1st Five project to assure early childhood healthy mental development by helping primary care practices to both identify at-risk young children and link them to Title V community-based care coordination resources.

CHSC hired a 0.4 FTE Pediatric Clinical Consultant to oversee the development of standards of care for CHSC's Clinical Services.

A CHSC internal workgroup was formed to design standardized approaches to deliver care coordination for children who receive CHSC Clinical Services, and to collect data for program planning and evaluation.

In June 2009, CHSC received a HRSA grant to implement a Family to Family Health Information Center that will combine the expertise of support groups throughout the state.

DIRECT AND ENABLING SERVICES
The CHSC Health and Disease Management Unit continued to provide care coordination to children with complex health care needs enrolled in Medicaid Waiver and EPSDT Programs under a contract with the Iowa Department of Human Services.

Telehealth consultations between CHSC regional staff and medical center-based child psychiatry for children with difficult behavioral problems was utilized, as was telehealth to connect CHSC regional dietitians to infants, toddlers, children and youth with feeding issues.

CHSC parent consultants functioned as service coordinators for young children with selected developmental conditions enrolled in Iowa's Early ACCESS (IDEA Part C) program.

Selected CHSC staff began delivering care coordination according to protocols designed by the care coordination work team.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC is developing a new approach to linking community-based care coordinators and prmary care providers to ultimately improve health outcomes and systems outcomes.				X
2. CHSC continues a major role in a SAMHSA-supported System of Care project to improve access, delivery, and coordination of mental health services for children with severe emotional disorders.				X
3. CHSC continues to use telehealth technology to improve families' access to clinical services, especially for children with behavioral problems.	X			
4. The CHSC Health and Disease Management Unit continues to provide care coordination to children with complex health care needs enrolled in Medicaid Waiver and EPSDT Programs under a contract with the Iowa Department of Human Services.		X		
5. CHSC embraced a new vision statement "to assure a system of care for cyshcn" and defined the system as containing four components: gap-filling direct clinical, care coordination, family support and infrastructure building.				X
6. The Iowa EHDI System of Care participated in a National Improvement in Child Health Quality (NICHQ) project that improved the quality of elements of the service system in one pilot region so that parents can use the services more easily.				X
7. The CHSC internal care coordination workgroup is spreading standardized approaches to deliver care coordination for children who receive CHSC Clinical Services, and continues to collect data for program planning and evaluation.				X
8. The Family to Family Health Information Center (F2F HIC) continues to be implemented and will be combined with a Family 360 Project that is subcontracted to CHSC by the Department of Human Services. The grants will work together to provide advice re				X

9.				
10.				

b. Current Activities
Iowa EHDI System of Care participated in a NICHQ project that improved the service system so that parents can use the services more easily.

CHSC joined the National Improvement Partnership Network to identify and integrate new quality improvement strategies in its programs and services.

CHSC staff participated in a SAMHSA-supported System of Care system improvement effort to develop a new, coordinated, family-driven system of care for children with severe emotional disorders.

The CHSC care coordination workgroup is spreading standardized approaches to deliver care coordination.

The Family to Family Iowa will provide advice re family support services and approaches to organizing services and develop web-based resources.

CHSC is conducting research regarding the social determinants of health and their potential impact on the needs of Iowa's families.

DIRECT AND ENABLING SERVICES:
The CHSC Health and Disease Management Unit continued to provide care coordination to children with complex health care needs enrolled in Medicaid Waiver and EPSDT Programs under a contract with the Iowa Department of Human Services.

Telemedicine consultations provided access to selected direct services (i.e. child psychiatry, nutrition, Applied Behavior Analysis for ASD).

CHSC parent consultants provided service coordination for young children with selected conditions enrolled in Iowa's IDEA Part C.

CHSC staff began delivering care coordination according to standardized protocols.

c. Plan for the Coming Year
Recommendations from the Iowa Autism Council to the Governor that are accepted by the Governor will be implemented.

CHSC will continue to implement organizational changes to actualize the vision statement "assure a system of care for CYSHCN" that includes four elements of gap-filling direct clinical, care coordination, family support and infrastructure.

Web-based resources via F2F HIC will be constructed so families and providers can access them conveniently.

Through NIPN, CHSC will explore ways to improve partnerships between pediatricians and subspecialty providers.

Iowa's EHDI System of Care will spread quality improvements learned from pilot regions, to remaining areas of the state.

Knowledge gained from cultural brokers will be implemented into EHDI and other programs and

services.

Knowledge generated from families, Early Childhood Iowa and other state level groups will continue to be used for education of policymakers and other key stakeholders.

DIRECT AND ENABLING SERVICES:
The CHSC Health and Disease Management Unit will continue to provide care coordination to children with complex health care needs enrolled in Medicaid Waiver and EPSDT Programs under a contract with the Iowa Department of Human Services.

Telemedicine services will continue for Serious Emotional Disturbances and nutrition. Using telemedicine to conduct diagnostic ABRS will be piloted within the EHDI System of Care.

CHSC parent consultants will continue to function as service coordinators for young children with selected developmental conditions enrolled in Iowa's Early ACCESS (IDEA Part C) program.

All CHSC care coordinators will receive ongoing training regarding new standards and procedures for delivering care coordination.

The Iowa EHDI System of Care will consult with cultural brokers to learn how to better serve targeted racial/ethnic groups.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.4	7	7.7	49.7	50.7
Annual Indicator	5.8	5.8	47.3	47.3	47.3
Numerator	310	310			
Denominator	5351	5351			
Data Source				NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	51.7	52.7	53.8	54.9	

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the transition services.

Notes - 2008

Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the transition services.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

We are hoping that participation in a technical assistance experience will boost our Title V CSHCN Program's accomplishments for this national priority outcome.

a. Last Year's Accomplishments
The FFY09 performance target objective of 50.7 percent was not met. The indicator value for Iowa was 47.3 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 11th highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC believes the indicator value is unsatisfactory, so has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES: CHSC co-led a SAMHSA-supported mental health System of Care project, which, according to family-driven and youth-guided principles, stands to be instrumental in facilitating effective transition for youth to adult care and independent living.

A study was published from work by MCH epidemiologists with CHSC consultation (using National Children with Special Health Care Needs Survey data) to investigate associations between individual, condition-related, and systems variables and prevalence of family-reported successful or unsuccessful receipt of transition services. (Kane DJ, Kasehagen L, Punyko J, Carle AC, Penziner A, Thorson S. What Factors Are Associated With State Performance on Provision of Transition Services to CSHCN? Pediatrics 124;S375-S383, 2009)

DIRECT AND ENABLING SERVICES: CHSC nurse care coordinators assisted families with eligible adolescents to enroll in Medicaid Waiver programs and, when relevant, to address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC's Pediatric Clinical Consultant is the Director of Adolescent Medicine Program at the University of Iowa Department of Pediatrics, and CHSC will capitalize on her expertise to infuse needs of adolescents into its programs and services.				X
2. Youth will continue to be represented on the F2F HIC/Family 360 Governance Council and the Iowa Autism Council.				X
3. CHSC will continue to co-lead a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.				X

4. Life Course Health Development concepts are being introduced to CHSC staff and will infuse adolescent needs.				X
5. CHSC's Health and Disease Management Unit will continue to assist families with eligible adolescents to enroll in Medicaid Waiver programs and, when relevant, to address transition issues, e.g. linking adolescents to Vocational Rehabilitation service	X			
6. Family 360 Navigator/care coordinator training will include topics relevant to youth and life course development				X
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: CHSC's Pediatric Clinical Consultant is the Director of Adolescent Medicine Program at the University of Iowa Department of Pediatrics.

Youth are represented on the F2F HIC/Family 360 Governance Council and the Iowa Autism Council.

Transitions for youth to adult health care activities are being implemented in CHSC's standardized care coordination protocols.

The topic of Microboards was presented to CHSC Parent Consultant Network and will be incorporated in F2F HIC and Family 360 resources.

CHSC co-lead a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.

DIRECT AND ENABLING SERVICES: CHSC's Health and Disease Management Unit will continue to assist families with eligible adolescents to enroll in Medicaid Waiver programs and, when relevant, to address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.

Family 360 Navigator/care coordinator training will include topics relevant to youth and life course development.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: CHSC's Pediatric Clinical Consultant, who has adolescent expertise, will lead efforts to assure standards of care for CHSC Clinical Services, including transition to adult services and other issues specifically required by youth.

CHSC's Pediatric Clinical Consultant will pursue opportunities to educate resident physicians in pediatrics, internal medicine and family medicine re the needs of transitioning youth with special health care needs.

Standardized care coordination protocols at CHSC and with Family 360 Navigators will infuse procedures that address needs of youth, including implications of Life Course Health Development theory.

Youth will continue to serve on the F2F HIC/Family 360 Governance Council and the Iowa Autism Council.

F2F and Family 360 will develop/access training and web-based resources for transition issues and publicize to families statewide.

CHSC will continue to co-lead a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living. The System of Care will continue to provide care coordination and to build support services for transitioning youth. Two examples of initiatives in the next year include ELEVATE, a support group for foster and adoptive youth who are interested in improving life connections for those in care by sharing their personal story.

DIRECT AND ENABLING SERVICES:
CHSC's Health and Disease Management Unit will continue to assist families with eligible adolescents to enroll in Medicaid Waiver programs and, when relevant, to address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	94	95	95	90	74
Annual Indicator	94.3	94.6	88.4	72.8	72.8
Numerator	5757	5469	5116	3930	3930
Denominator	6105	5781	5786	5395	5395
Data Source				PSIA report	PSIA report
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	73	73	74	75	75

Notes - 2009
Iowa is reporting 2008 data from the PSIA report for 2009 due to lack of data. Iowa is exploring the implementation of a county level survey for immunization status data.

Notes - 2008
2008 Data were obtained from the 2009 Public Sector Immunization Assessment report. The decrease in the percentage of children fully immunized between 2007 and 2008 can be attributed to a change in assessment protocol as well as the national Hib shortage.

Notes - 2007
Data were obtained taken from the 2008 Public Sector Immunization Assessment report.

a. Last Year's Accomplishments
The FFY09 performance target objective of 74 percent was not met. The indicator value for Iowa was 72.8 percent based on data from the 2008. The Immunization Program is no longer

reporting Immunization Rates using the Public Sector Immunization Assessment report and is explore the implementation of county level survey for immunization status. IDPH is working on the final approval and the Immunization Bureau will be using the county data source next year. Another data sources used to assess immunization status is the National Immunization Survey conducted through CDC, which is data for 19 -- 35 months of age. The most recent NIS data available is for quarter three/2008- quarter two/2009. Iowa is at 60.5 percent for the 4:3:1:3:3:1:4 series compared to 65.7 percent nationally. The numerator and denominator for statewide data are not made available through this national report.

The immunization program continues to focus on enrolling public and private immunization sites in the Vaccine for Children program. As of December 31, 2009 there were 591 public/private sites enrolled.

Of the 180 private clinics that have received an AFIX/VFC visit; 70 percent of children assessed have received 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B and 1 varicella vaccines by 24 months of age.

In 2009, (45 percent) Local Public Health Agencies (LPHA) provided vaccines to adolescents though school based clinics.

Data from the 2008 National Immunization Survey Teens (NIS Teen) reports on adolescents, 13-17 years of age. Iowa's data are as follows:
o 2 MMR --- 86.4 percent
o 3 Hepatitis B ---- 79.2 percent
o 1 Varicella --- 68.4 percent
o 1 Td or Tdap --- 65.9 percent
o Tdap only ---- 43.5 percent
o Meningococcal --- 31.9 percent
o At least 1 HPV --- 41.9 percent

The Immunization program provided support for increasing the awareness of immunization related to adult health. In FFY09 91 local public health agencies provided influenza vaccine and 40 agencies that provide pneumococcal vaccine.

The Perinatal Hepatitis B Program continues to increase efficiency of case management for newborns of HBsAg positive women. In 2008, the Immunization Program partnered with the Bureau of Vital Statistics to receive updates of mother/baby pairs reported on birth certificates to be HBsAg positive. This led not only to "finding" several unknown HBsAg positive women but also to improvement in reporting by hospitals, as some mothers were incorrectly identified as HBsAg positive when they were GBS positive. This process has continued in 2009 and has become an electronic exchange of information.

In 2009, the Immunization Program initiated a pilot project with the use of ARRA vaccine funds to vaccinate all newborns regardless of VFC eligibility with the birth dose of hepatitis B.

As of December 31, 2009, IRIS has 929 providers enrolled with 2,006,691 patient records and 16,746,153 immunization records.

The Immunization Program spent significant time focusing on H1N1 in Iowa over the past year.
o 953 H1N1 Provider Agreement Forms were submitted by providers willing to administer the H1N1 vaccine.
o 165 new IRIS users of which the majority were added because of H1N1.

Beginning January 2009 and continuing through December 31, 2011, Iowa has been involved in an evaluation which ensures the quality of a VFC/AFIX site visit and focuses specifically on the

importance of the feedback session during the AFIX portion of the visit.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recruit new private practice physicians to use the IRIS data system.				X
2. Provide immunization training and in services for VFC providers.				X
3. Continue to provide technical assistance to local maternal and child health, WIC, and public health agencies.				X
4. Collaborate with the Dept of Education on data exchanges to assure complete immunization records.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Funding is provided to local public health agencies and community health centers for immunization services. Some agencies conduct satellite clinics and collaborate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to provide immunizations. All primary care providers are encouraged to use IRIS. As of December 31, 2009, there are 929 providers enrolled in IRIS. This includes both private and public providers, hospitals, long-term care facilities and pharmacies. Public providers include local public health agencies, local MCH contract agencies, Federally Qualified Health Centers/Rural Health Clinics, and other public clinics that provide immunizations. Local MCH contract agencies continue to monitor immunization status and offer counseling to families receiving EPSDT care coordination services. This includes Title XIX/Medicaid clients not served by an HMO.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: The number of private providers using IRIS will continue to increase due to outreach of the Immunization Bureau. Local CH contract agencies will continue to monitor immunization status and offer counseling to all families served.

All local CH contract agencies will address immunization as a component of informing and care coordination provided to families enrolled in Medicaid. The Immunization Program is working on a registry up-grade, an interface with Vital Statistics records and interoperability between IRIS and electronic medical records.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	14.7	14.7	16	15	16

Annual Indicator	16.1	16.7	15.6	16.8	15.7
Numerator	963	999	973	1025	945
Denominator	59906	59906	62364	61192	60016
Data Source				Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.2	15	15	15	15

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics provisional data.

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

a. Last Year's Accomplishments
The FFY09 performance objective of 16 per 1,000 was met, though the value of the objective was increased due to the trend of increasing rate of teen births. Data from Iowa Vital Statistics shows the rate of birth (per 1,000) for teenagers aged 15 through 17 years in 2009 was 15.4 percent. Iowa continues to monitor teen birth due to the fluctuation of annual indicator values. Iowa continues to monitor contraceptive use and the need for public awareness campaigns.

INFRASTRUCTURE BUILDING SERVICES: Iowa continued to promote research on science-based practices in pregnancy prevention. Science-based practices include techniques, characteristics, activities and programs for which there is evidence of effectiveness. MCH Title V and OPA Title X programs, directed by IDPH, are closely coordinated.

In 2006, DHS received approval from the Centers for Medicare and Medicaid to implement the Iowa Family Planning Network (IFPN), which waives section 1115 of the Medicaid rules. IFPN was implemented on February 1, 2006. The program extends Medicaid coverage for only family planning services to women who had Medicaid covered pregnancies and deliveries and to all women ages 13 to 44 whose income is below 200 percent of federal poverty.
Information for eligibility determination for this program is obtained at family planning clinics, as well as DHS offices. The notice of determination of eligibility for the program and clinical services can be obtained at the family planning clinic from the DHS secure Website the day a woman applies for the program. Almost all of the women determined eligible for the program applied at family planning clinics.

At the IDPH Bureau of Family Health Fall Conference in October 2009, a panel of youth discussed adolescent health care needs and offered ideas for making clinic settings more youth-friendly. In 2009, workshops were conducted to assist delegate agencies in the use of electronic media to reach adolescents. In September, Title X services brochures were provided to Iowa Department of Education staff for use in teacher training seminars on HIV/STI prevention and pregnancy prevention.

ENABLING SERVICES: IDPH contracted with eight Title X Family Planning (FP) programs to conduct outreach and educational programs in 45 of Iowa's 99 counties. Developmentally appropriate educational programs stressed the value of abstinence, encouraged communication with parents, emphasized responsible decision making, the avoidance of coercive sexual activity and information on pregnancy and STI/HIV prevention. A focus of FP programming was to provide clinical services to adolescents (ages 20 or younger). One of the goals for the FP program was to maintain the number of adolescents served, at least 5,277 (CY 2004) clients, which was achieved in 2009 with 5,337 adolescents served.

2004: 5277 adolescents served
2005: 5030 adolescents served
2006: 4892 adolescents served
2007: 4821 adolescents served
2008: 5002 adolescents served
2009: 5337 adolescents served

The data below reflects the increasing number of adolescent males served from 2006 -- 2009:

2006: 145
2007: 151
2008: 190
2009: 224

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assuring ongoing high quality family planning and related preventive health services, where evidence exists that those services will improve the overall health of individuals, with priority for services to individuals from low-income families.	X	X	X	
2. Expanding access to a broad range of acceptable and effective family planning methods and related preventive health services.	X	X	X	X
3. Assuring compliance with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.			X	X
4. Emphasizing the importance of counseling family planning clients on establishing a reproductive life plan.				X
5. Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.	X	X	X	X
6. Addressing the comprehensive family planning and other health needs of individuals, families, and communities through outreach to hard-to-reach and/or vulnerable populations, and partnering with other community-based health and social service provide		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

During FFY10, the overall Family Planning objectives remain focused on improving the quality and quantity of services to Iowa's three priority populations (minorities, adolescents and males); increasing the number of pregnancies in Iowa that are intended; promoting long acting reversible contraceptive use and developing sustainable IDPH family planning clinics positioned to serve an increased number of clients.

c. Plan for the Coming Year

In June 2010, IDPH applied for the comprehensive adolescent pregnancy prevention programs from the newly authorized DHHS Office of Adolescent Health. Iowa's grant proposes a research project partnering with local family planning and local maternal health agencies. The University of Iowa, College of Medicine will conduct the evaluation component of the project.

IDPH will continue to provide information to minors about all contraceptive methods, including abstinence.

IDPH will implement its objectives for year three of the five year Title X plan, including expanding the services to minorities, adolescents and males. Minorities and adolescents are disproportionately affected by reproductive health issues and the male role in family planning remains underestimated.

Outreach plans to adolescents and males include: 1) continuing to investigate and disseminate best practices for working with adolescents; 2) expanding the use of electronic media to reach youth; 3) expanding the role of youth on the state family planning Information and Education Committees; 4) continuing work with the Iowa Department of Education staff informing them of Title X services for use in their HIV/STI prevention and pregnancy prevention curricula; 5) developing more formalized partnerships between Title X agencies and the foster care, intimate partner violence and substance abuse community resources; 6) collaborating with other state agencies for increased funding for adolescent pregnancy prevention efforts in Iowa.

Title X clinics will initiate efforts to assure that all clients, including adolescents and males are counseled about the importance of establishing a reproductive life plan (RLP) to set personal goals about having (or not having) children. The RLP will also describe plans to achieve those goals.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	44	46	45	47	50
Annual Indicator	45.5	44.0	44.5	49.2	48.5
Numerator	15500	15198	15446	17336	16962
Denominator	34064	34540	34709	35235	34972
Data Source				third grade survey	third grade survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
Based upon the results of the 2009 3rd grade survey conducted by OHB, a data consultant for Iowa's Title V application used a forecast formula to estimate the sealant rate this year.

Notes - 2008
The data was collected on the OHB sealant survey for third graders in 2008.

Notes - 2007
The OHB previously conducted an annual sealant survey to determine this rate for the past eight years. Based upon the results of the data collected, a careful evaluation of the statistical significance or cost effectiveness to continue the annual survey was done. A decision of repeating the survey every third year was made. The statistician for Iowa's Title V application will continue to use the forecast formula to estimate the sealant rate every other year.

a. Last Year's Accomplishments
The FFY09 performance objective of 50 percent was not met. Iowa's 2009 data showed 48.5 percent of third graders received protective sealants. The Oral Health Bureau (OHB) has been involved in providing training to primary care providers on the importance of sealants and fluoride varnish. Staff also continues to promote the I-Smile™ project at the state and local level. At the state level the Oral Health Bureau and the local maternal and child health agencies partnered with local school districts on the implementation of the mandatory dental screen prior to school entry.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Train primary care providers on the importance of sealants and fluoride varnish.			X	X
2. Continue to promote I-Smile™ project at the state and local level.				X
3. Partner with local school districts on the implementation of the mandatory dental screen prior to school entry.			X	X
4. Incorporate changes to CAReS to capture the number of children with a sealant.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
POPULATION BASED SERVICES: Seven school-based sealant programs were in their final contract year with IDPH. During the 2009-10 school year, 16,962 sealants were placed. Six I-Smile™ projects also conduct or participate in sealant programs that are not funded by IDPH, though OHB staff provides technical assistance as needed. In addition, the spring I-Smile™ coordinator meeting included a panelist and round table discussion about starting and sustaining

school-based sealant programs.

Promoting and providing preventive services continues to be a focus within the Title V system. OHB staff updated all written educational materials, available in hard copy or online. Over 40,600 fluoride varnish applications were provided in FFY2009. New data reports are available to OHB in FFY2010 to identify the number of screened children who have a dental sealant. Data collected by Title V service areas further assist in targeting promotion and program efforts.

INFRASTRUCTURE BUILDING SERVICES: OHB staff met with representatives from Delta Dental of Iowa Foundation (DDIF) to discuss a possible public-private collaboration that would increase overall funding for school-based sealant programs around the state. DDIF is seeking ways to increase their role in dental disease prevention at a community level and are considering partnering with OHB to enhance the existing sealant program structure in the state.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: A new five year project period for school-based sealant programs will begin in October, through a competitive bid process. Based on results of the 2009 Oral Health Survey, IDPH is considering methods to prioritize applicants with a higher number of uninsured and/or African American children within their service areas. OHB staff will also continue to pursue a public-private partnership with Delta Dental of Iowa Foundation regarding their interest in funding for school-based sealant programs in the state. OHB staff will work with Title V contractors to maintain planning for "Give Kids a Smile Day" events in February, including a request to emphasize using the day for preventive care such as sealant application.

POPULATION BASED SERVICES: The school dental screening requirement, enacted in 2009, offers additional contact for OHB staff with school nurses and a venue for promoting dental disease prevention. Through Iowa's Targeted Oral Health Service Systems grant, OHB staff will develop a plan that will further emphasize the importance of preventing decay with early care, fluoride, and sealants. Promotion may also include development of materials that can be offered to businesses and linkages with the hawk-i program, which now offers a dental-only option for families.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	4.1	2	4.5	3
Annual Indicator	4.4	2.1	4.6	2.9	3.1
Numerator	24	12	25	17	18
Denominator	547627	581387	543571	586749	586749
Data Source				Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	2	2	2	2

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

a. Last Year's Accomplishments
The FFY09 performance objective of 3.0 percent was not met. Iowa's 2009 Vital Statistics provisional data indicate the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children was 3.1 percent. This rate is still provisional as it based on the 2008 population data for children aged 14 and younger.

INFRASTRUCTURE BUILDING SERVICES: The Bureau of EMS-EMSC and Injury Prevention Programs worked with the Iowa Safe Kids Coalition and other nonprofit injury prevention organizations to support statewide child passenger safety check-ups at community events, as well as regularly scheduled child passenger safety inspection stations. During FFY09, certified technicians were available to inspect child passenger safety seats at 29 Fit (Inspection) Stations throughout the state. The Fit Stations hosted monthly events or served their community by appointment. A total of 669 new seats were distributed to families. Child passenger safety advocates worked to provide outreach to physicians, health care agencies, and child care providers.

Physician outreach promoting child passenger safety continues. Physicians have the opportunity to educate families with young children about appropriate child passenger safety systems, and materials are provided at no cost. Outreach in child care settings and schools assure that a broad population receives education on appropriate occupant protection.

Youth outreach groups led by the Iowa Health System are presenting the "Think First! Injury Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

POPULATION BASED SERVICES: The Bureaus of Family Health and EMS-EMSC, and the Iowa Safe Kids Coalition are collaborating to provide outreach to childcare providers and families. Information regarding recalls of child safety seats and bicycle safety around cars is provided online. More information can be found on the Healthy Child Care Iowa Website (http://www.idph.state.ia.us/hcci/products.asp).

Training continued for certified child passenger safety technicians. Four CPS certification trainings were conducted for FY09. Technicians received continuing education on new trends in occupant protection at the annual CPS Technician Workshop.

One local contract agency focused on decreasing child mortality related to motor vehicle accidents. The local agency focused on distribution of car seat safety materials, certified car safety seat inspectors provide education and demonstrations at community events.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education to health care providers on car seat safety.				X
2. Provide child passenger safety check-ups across Iowa.	X		X	
3. Educate early care providers on the importance of car seat safety through child care nurse consultants.				X
4. Continue to be actively involved with the Iowa Safe Kids Coalition.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

POPULATION BASED SERVICES: Activities to decrease the mortality rate include a campaign focusing on pedestrian safety. The plan is to educate children on safe street crossing and proper utilization of sidewalks. Targeted interventions to encourage booster seat usage are also planned. A needs assessment will be completed and the results compiled in order to address the areas where education is needed. This education will involve demonstration of proper booster seat installation and booster seat checks.

Community outreach activities include "spot the tot" training, which teaches drivers to keep their eyes on children while backing up.

Updated car seat safety inspection cards will be developed. The car seat safety inspection cards will be distributed at community events.

c. Plan for the Coming Year

CPS Tech courses will be offered with a minimum of four classes per year throughout the state and inspection stations will continue to be held on a regular basis. There will also continue to be an Annual Technician Update to provide the technicians continuing education on new trends in occupant protection.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		28	35	46	20
Annual Indicator	27.5	34.7	20.1	20.0	18.1
Numerator	10496	103	2903	2927	2692
Denominator	38133	297	14444	14633	14871
Data Source				Pediatric NSS	Pediatric NSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19	20	21	24	25

Notes - 2009
2009 data is from the 2009 Pediatric Nutrition Surveillance Survey. The data show that 18.1 percent of the 14,871 infants in the data set were breastfed at six months of age.

Notes - 2008
2008 data is from the 2008 Pediatric Nutrition Surveillance Survey. The data show that 20 percent of the 14,633 infants in the data set were breastfed at six months of age.

Notes - 2007
2007 data is from the 2007 Pediatric Nutrition Surveillance Survey. The data show that 20.1 percent of the 14,444 infants in the data set were breastfed at six months of age.

a. Last Year's Accomplishments
The FFY09 performance objective of 20 percent was not met. Data from the Pediatric Nutrition Surveillance Survey show 18.1 percent of mothers breastfeed their infants at 6 months of age.

The Bureau of WIC and Nutrition staff continued to provide technical assistance to local maternal and child health agencies on breastfeeding. State and local WIC staff also continued to be involved in the Iowa's Fit for Life early childhood workgroup that focused on implementation of family friendly policy recommendations on breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide technical assistance to local maternal and child health agencies on breastfeeding.				X
2. Co-sponsor the annual breastfeeding conference.				X
3. Continue to be involved with the Iowans Fit for Life Early Childhood workgroup to implement family friendly policy recommendations on breastfeeding.		X		X
4. Become involved with the Iowans Fit for Life Worksite workgroup to help implement worksites becoming breastfeeding friendly.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: The IDPH Bureau of Nutrition and Health Promotion requires local contract agencies to expend a minimum of 20 percent of the total allocated Nutrition Program for Women, Infants, and Children (WIC) funds on nutrition education, including a minimum of three percent to be spent on breastfeeding promotion and support.

ENABLING SERVICES: The Bureau received a USDA-Peer Counseling grant since 2004. The purpose of the grant is to start a peer-counseling program. One pilot project was started in local WIC agencies in 2005. In 2008, four additional agencies started peer counselor programs. Evaluation of the peer agencies continue on a yearly basis. The five agencies currently have 18 peer counselors with each peer serving an average of 49 clients. Two additional peer agencies were added March 2010 with plans to hire three peers per agency.

DIRECT HEALTH CARE SERVICES: All 20 WIC agencies, including 14 that integrate Title V services, implemented action plans targeting community-based breastfeeding promotion and support. Planned activities of local WIC contract agencies include: breastfeeding fairs for pregnant women, breastfeeding education and support to communities, and continuing education to community partners on the new food package implemented by WIC on October 1, 2009 and contacting businesses to discuss worksite lactation policies throughout the state.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: The Bureau of Nutrition and Health Promotion staff will provide technical assistance on breastfeeding to the local contract agencies. Local maternal health contract agencies will continue to develop and implement community-based strategies for breastfeeding. IDPH will continue to support the seven agencies that have WIC breastfeeding peer counselor programs. Staff will also visit area businesses to discuss setting up a lactation area if they do not have one already.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	98	99.8	99	99.5
Annual Indicator	95.7	97.4	98.2	98.7	98.7
Numerator	35757	37970	39684	39545	38885
Denominator	37360	38996	40414	40052	39404
Data Source				eSP	eSP
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99.6	99.7	100	100	100

Notes - 2009

The 2009 data were obtained from the eSP newborn hearing screening data base. The total number screened may not include children that were not screened by the birth hospital because they were transferred to another facility before screening, missed, or the family refused. The total eligible for screening is birth by occurrence.

Notes - 2008

The 2008 data were obtained from the eSP newborn hearing screening database. The total number screened may not include children that were not screened by the birthing hospital because they were transferred to another facility before screening, missed or the family refused. The total eligible for screening is birth by occurrence.

Notes - 2007
The 2007 data were obtained from the eSP newborn hearing screening data. The total number screened may not include children that were not screened by the birth hospital because they were transferred to another facility before screening, missed, or the family refused. The total eligible for screening is birth by occurrence.

a. Last Year's Accomplishments
The FFY09 annual indicator objective of 99.5 percent was met. Since 2005, the screening rate continued to increase each year until 2008 when it has remained consistent at approximately 99 percent. The program has a Web-based data system used for reporting newborn hearing screen results, as well as outpatient screens and diagnostic hearing assessments. The number of quality assurance checks completed monthly and quarterly has increased over time to ensure accurate reporting.

The Iowa Early Hearing Detection and Intervention (EHDI) program staff began conducting site visits with Iowa birthing hospitals in 2009. Each hospital receives periodic visits regardless of performance. The goals of the visits were to:
• Identify strengths and best practices in hospital newborn hearing screening programs
• Clearly understand best practices so they can be recommended to other hospitals
• Identify areas for improvement in hospital newborn hearing screening programs
• Identify hospital technical assistance (TA) needs
• Identify areas for improvement in the Iowa EHDI program
The visits have proved successful as a number of hospitals have implemented recommended best practices.

The EHDI program had a number of meetings in 2009 with the Bureau of Vital Statistics and the Metabolic Screening program to explore data integration or data linkage. In addition, the EHDI program conducted a data match between EHDI and Early ACCESS hearing module to ensure children diagnosed with hearing loss are enrolled before six months of age.

The EHDI program participated in a number of outreach and public education opportunities regarding the program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical assistance to hospital, Area Education Agencies, health care providers and private practice audiologists.				X
2. Continue to monitor eSP data.				X
3. Use pediatric audiologist to provide technical assistance to facilities providing newborn screening.			X	X
4. Provide training to early childhood professionals on childhood hearing loss.			X	X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: The EHDI program drafted a quality assurance protocol for hospitals to ensure sustainability within the hospital programs. EHDI audiology technical assistants continue to provide training on newborn hearing screening to reduce the number of children that refer on the initial birth screen.

The EHDI program continues to participate in the "Improving the System of Care for CYSCH: Epilepsy and the Newborn Hearing Screening Programs" Learning Collaborative through the National Initiative for Children's Healthcare Quality.

A data team workgroup was developed to address training issues as a result of the EHDI-EA data match. Data sharing mechanisms will be implemented between EHDI and Early ACCESS to ensure children diagnosed with hearing loss are enrolled before six months of age. To ease data sharing between the two programs, EA service coordinators will obtain consent to release information at first contact so the information can be shared with the EHDI program.

POPULATION BASED SERVICES: Eighty-one birthing hospitals provided universal newborn hearing screening services as required by law.

ENABLING SERVICES: The EHDI program sends letters to families and physicians of children with risk factors for hearing loss to provide recommended follow-up protocol as well as provides family support services to families of children with hearing loss through the Iowa Guide by Your Side program.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

EHDI staff will continue their efforts to educate midwives, primary care providers, audiologists and ENTs about the importance of timely screening and follow-up for children who do not pass the initial screen or have risk factors for late-onset hearing loss.

The EHDI program will continue work to spread effective strategies learned through the NICHQ learning collaborative to facilities across the state that provide newborn hearing screens, outpatient screens and diagnosis for children under the age of three.

EHDI will continue program evaluation on various aspects including hearing screening, follow-up, referral, early intervention, family support and data reporting. Evaluation results will be shared with the EHDI Advisory Committee and other partners to help guide policy and program development.

POPULATION BASED SERVICES: All birthing hospitals will provide universal newborn hearing screening services as required by law. The EHDI program will also work with birthing facilities that have NICUs to implement AABR screening as a standard of care as recommended by the Joint Committee on Infant Hearing Screening. The EHDI program will participate in outreach and public education opportunities regarding the program.

ENABLING SERVICES: IDPH and CHSC will continue to work with Center for Disabilities and Development (CDD) audiologists to provide training to hospitals and AEA staff with an emphasis on "refer" and "miss" rates, as well as timely follow-up, including referral for diagnostic assessments and/or Early ACCESS and family support.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	2	2.7	2.6	2.8
Annual Indicator	2.8	2.8	2.8	2.8	2.8
Numerator	20640	19124	19919	19852	19969
Denominator	737212	683000	711403	709000	713155
Data Source				Household Health Survey	Household Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.8	2.5	2.5	2.5	2.5

Notes - 2009
The annual indicator reflects the results of the 2005 Household Health Survey as noted in previous years. It remains difficult to estimate the percent of uninsured children in Iowa. Data from the most recent (2008) Census Population Survey (CPS) conflicts with this estimate, which errors in measurement and the use of differing data sources.

Notes - 2008
The annual indicator reflects the results of the 2005 Household Health Survey as noted in previous years. It remains difficult to estimate the percent of uninsured children in Iowa. Data from the most recent (2007) Census Population Survey (CPS) report the uninsured rate at 4.8%, however, variations in conflicting reports suggest errors in measurement and the use of differing data sources.

Notes - 2007
The numerator was obtained from the 2005 Child and Family Household Health Survey data. The denominator was obtained from the 2006 Census data for children <18 years.

a. Last Year's Accomplishments
The FFY09 performance objective of 2.8 percent was met. Data from the 2005 Household Health Survey shows a 2.8 percent of uninsured children in Iowa.

Due to the lack of dedicated funding, Iowa Covering Kids and Families (CKF) ended in 2009. Key CKF activities were integrated into existing programs such as the hawk-i Outreach Taskforce, the Polk County urban-based Healthcare Coverage for Kids Coalition (HCKC) and Iowa's Title V agency MCH programs.

In FFY09, the Iowa Department of Human Services (DHS) continued to contract with IDPH to provide oversight of the local grassroots hawk-i outreach across the state. Over the previous year, IDPH and the local child health agencies built upon the successes from the previous year and made new gains in previously unexplored areas. Outreach coordinators received trainings

throughout the year assisting them with their outreach efforts. In addition to individualized training, outreach coordinators participated in two outreach taskforce meetings, where best practices were shared and program updates were given.

Statewide outreach targeted large venues, including events such as Iowa's Latino Festival, the Statewide Asian Festival, and I'll Make Me A World African American Celebration event and tax assistance sites for those who qualify for the Earned Income Tax Credit.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhance outreach to special populations.				X
2. Continue to oversee the hawk-i outreach contract with local child health agencies.				X
3. Promote the public awareness campaign on hawk-i.				X
4. Provide technical assistance to local child health agencies.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Iowa's Medicaid and CHIP administrators continue work on the Retention Initiative, including efforts to align policies of multiple programs to allow for simplified and streamlined application processes. DHS implemented two large systems in March of 2010. Iowa was the first state in the nation to implement a dental only program under its Children's Health Insurance Program. The hawk-i dental program is a supplemental dental only program designed for families who may already have health care coverage for their children, but lack dental health coverage.

DHS also implemented presumptive eligibility for children. The department designed a presumptive eligibility program that allows "qualified entities" to become certified to make presumptive determinations through a Web-based provider portal. All presumptively eligible children will be enrolled in Medicaid until a formal eligibility determination is made. Upon determination, the child will either remain in Medicaid or move to hawk-i health care coverage.

POPULATION BASED SERVICES: Local outreach coordinators continue to educate families and primary care providers about Iowa's health insurance options. Coordinators continue to focus efforts on outreach to health care providers, schools, the faith based community and special ethnic and vulnerable populations.

ENABLING SERVICES:
Outreach coordinators assist families in navigating the Medicaid and hawk-i enrollment and renewal process.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: Iowa's CHIP administrators have indicated the primary focus for FFY2011 for Iowa's CHIP program will be finalizing and maintaining the presumptive eligibility for children system. It is Iowa's intention that providers deemed qualified to

determine eligibility or "Qualified Entities" will include local child health contract agencies, Iowa school nurses, and primary care physician offices. All hawk-i outreach coordinators will certify Qualified Entities and local outreach efforts will focus on enrolling children in Medicaid and hawk-i through the presumptive eligibility for children system.

DHS will be designing an Express Lane Eligibility (ELE) process that will enroll children who receive Food Assistance, but not Medicaid, into the Medicaid program. It is anticipated that the ELE will be expanded to include programs outside of DHS in years to come.

POPULATION BASED SERVICES: The primary focus of outreach across Iowa will be to increase enrollment of Iowa's children in Medicaid and hawk-i by utilizing the presumptive eligibility for children system. Local hawk-i outreach coordinators will be required to continue outreach to health care providers, schools, the faith based community, and ethnic and vulnerable populations. The focus of all outreach will be on hawk-i, the hawk-i dental only program, and presumptive eligibility for children. Outreach coordinators will also focus on recruiting qualified entities to become certified in making presumptive eligibility determinations for children in their communities.

ENABLING SERVICES: Outreach coordinators will continue to help families enroll and renew their enrollment in Medicaid and hawk-i. As a result of the new hawk-i dental only program, outreach workers will also assist families in enrolling in the dental only option offered by hawk-i. Coordinators will continue to identify barriers through the use of occurrence reports and other forms of established communication.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13	30	30	32
Annual Indicator	14.0	32.5	32.5	32.6	32.3
Numerator	9205	9802	9802	10936	11326
Denominator	65753	30161	30161	33548	35112
Data Source				CDC PedNSS	CDC PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30	29.8	29.7	29.6	29.5

Notes - 2009
PedNSS data for 2009 will not be available until later this year. Data presented is projected based upon anticipated caseload. Numerators and denominators are calculated from the number of children tested by WIC, 2 to 5 years, compared with those having a Body Mass Index (BMI) at or above the 85th percentile.

Notes - 2008

The 2008 data are calculated from the number of children tested times the percent with BMI >85th percentile as reported in CDC PedNSS Reports.

Notes - 2007
PedNSS data for 2007 will not be available until later this year.
Numerators are calculated from the number of children tested x percent with BMI >85th percentile as reported in CDC PedNSS Reports.

a. Last Year's Accomplishments
The FFY09 performance objective of 32 percent was met. Iowa's PedNSS data for 2009 was 32.3 percent. Data presented is projected based upon anticipated caseload.

Iowa continues to focus efforts on implementing strategies from the Healthy Kids Act legislated in 2008. The Healthy Kids Act is a collaboration with the Department of Education, Human Service and Public Health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer regional interactive Value Enhanced Nutrition Assessment (VENA) trainings.				X
2. Implement the strategies in the Healthy Kids Act.				X
3. Promote fruit and vegetable consumption using the Pick a Better Snack social marketing materials in 2008.				X
4. Promote breastfeeding-friendly worksites in the state.				X
5. Provided five trainings for Family Support Staff.				X
6. Provide consumer skills modules to WIC agencies.				X
7. Conduct a low fat milk campaign in WIC.				X
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: IDPH continues to offer the following trainings: Value Enhanced Nutrition Assessment (VENA) Communication skills training; Business Case for Breastfeeding trainings; and Nutrition and Physical Activity Training for Family Support staff. Bureau staff will also be evaluating the use of the California Market to Meals campaign and seek other materials promoting planning, preparing and purchasing healthy foods for use in WIC clinics. Bureau staff are developing materials for participants that will ease transition to low fat milk, educate participants on purchase and use of fruits and vegetables and whole grain products.

BASICS staff is working with schools and child care centers through the BASICS Program, funded through the Food Stamp Nutrition Education program, to provide funding and resources to provide pick a better snack and ACT classroom nutrition education.

Communities Putting Prevention to Work: State and Territories provides funding for two initiatives in Iowa. Both are supported by the work of the Iowans Fit for Life Early Childhood Work Group.
o Providing training to birthing hospitals to establish improved breastfeeding policy using Baby Friendly Hospital Initiative policy recommendations.
o Developing trainings and resources for child care providers to encourage a television viewing policy limiting screen time and increasing physical activity.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: Local agencies and WIC vendors will be provided materials to facilitate using fruit and vegetable vouchers provided by the WIC program. Snack recipes using WIC foods will be also be provided to agencies. These recipes will utilize fruits, vegetables, and whole grains. Agencies will continue to counsel caregivers in the WIC program to focus on assuring their families move to a healthier life style which includes healthy foods and regular exercise.

Through leadership from Fit for Life and Healthy Communities staff the Live Healthy Iowa Kids/Governor's Challenge will promote a free 100 Day Challenge for youth teams to track progress on the following components:

a. Physical Activity
b. Screen time
c. Consumption of fruits and vegetables
d. Consumption of low fat milk
e. Consumption of water

The Iowa Department of Public Health received an ARRA grant that focuses on working with child care center to limit screen time and encourage physical activity. IDPH is working with the Department of Human Services Child Care Bureau, Early Childhood Iowa, Healthy Child Care Iowa and child care nurse consultants on implementation activities.

The Health Promotion Unit will also be working on a Baby-Friendly Hospital Initiative to reduce screen time in child care centers. The Baby Friendly Hospital Initiative promotes policies in birthing hospitals that support breastfeeding. A staff person will develop and provide trainings for hospital staff at birthing hospitals throughout the state of Iowa and share information on implementing breastfeeding-friendly policies. The child care screen time project promotes screen time limitations in child care centers and provides active alternatives to screen time to increase physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		17	18	14	14
Annual Indicator	17.9	18.0	14.9	14.5	13.6
Numerator	3265	3284	6075	5846	5387
Denominator	18241	18247	40788	40221	39662
Data Source				Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13	12	11	10	9

Notes - 2009

2009 Data were obtained from 2009 Vital Statistics data.

Notes - 2008
2008 Data was obtained from 2008 Vital Statistics data.

Notes - 2007
Data was obtained from 2007 Vital Statistics provisional data.

a. Last Year's Accomplishments
The FFY09 performance objective of 14 percent was met. Iowa's 2009 Vital Statistic data show that the percentage of women who smoked in the last three months of pregnancy was 13.6 percent.

INFRASTRUCTURE BUILDING SERVICES: Staff are expanding tobacco cessation training for dental hygienists and local I-Smile coordinators. The training is being offered to WIC staff at the annual statewide conference.

IDPH staff and Iowa Medicaid Enterprise developed a task force to follow up on the Medicaid Match report which indicates that Iowa mothers enrolled in Medicaid are smoking during pregnancy at a higher rate than the national average. The taskforce is exploring strategies to reduce tobacco use in pregnant women. Additionally, analysis of Iowa PRAMS pilot is exploring Iowa women's tobacco usage.

Training was offered on a brief tobacco cessation intervention model at the Bureau of Family Health Fall Seminar in 2009. This session was attended by 32 local MH contract agency staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train on the tobacco intervention model to local agencies.		X		X
2. Expand tobacco cessation training to dental hygienists, local I-Smiles coordinators, and WIC staff.		X		X
3. Work with Medicaid leadership to decrease the number of Medicaid women smoking during pregnancy.				X
4. Utilize Iowa PRAMS pilot which will allow a second year of improved data collection.				X
5. Meet monthly with ACOG, Planned Parenthood, AMCHP and tobacco bureau staff.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: The Division of Tobacco will implement a statewide media campaign targeting women ages 18-44 on tobacco cessation efforts, produce educational materials specific to cessation among women ages 18-44 and complete training in all 20 Planned Parenthood clinics to implement a brief tobacco intervention. The division is also reaching out to women's health providers through an existing provider outreach contract with the Iowa Tobacco Research Center at the University of Iowa to provide training in brief tobacco cessation counseling.

Medicaid pays for nicotine replacement therapy (NRT) with permission for use of NRT during pregnancy as long as the client will commit to counseling through Quitline Iowa, a toll-free telephone tobacco cessation counseling service. Local MH agencies and FP agencies have been trained in making fax referral for this service. Medicaid also added payable codes for local MH agencies to allow oral hygienists to provide tobacco cessation counseling to prevent oral health disease.

IDPH collaborated with the Division of Tobacco Use, Prevention and Control on the following activities:
• Provided education to MH agencies on "Ask, Advise, Refer," a brief tobacco cessation intervention.
• Provided training on motivational intervention. The motivational interviews assist patients in making progress toward readiness to quit smoking.
• Developed a relapse prevention program for pregnant women who have quit smoking during pregnancy.

c. Plan for the Coming Year
Continue to collaborate with Division of Tobacco and Title V Maternal Health and Title X Family Planning Programs to ensure that all women of childbearing age are asked every visit about tobacco use, advised to quit and referred to Quitline Iowa.

Evaluate Division of Tobacco the provider training, considering other providers that may still need training.

Explore Medicaid support for reimbursement of brief tobacco cessation intervention provide by Title V MH nurses.

Encourage post-partum follow-up care coordination for all women who quit smoking during pregnancy to enroll them in the relapse prevention program.

Provide education to Child Health program staff on dangers of second hand smoke and encourage assessment of exposure to second-hand smoke and referral care coordination to link families to Quitline Iowa when appropriate.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	9.8	12.7
Annual Indicator	11.0	10.6	10.1	12.9	9.7
Numerator	23	23	22	28	21
Denominator	209303	217268	217502	216795	217380
Data Source				Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.5	9.4	9.3	9	9

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

a. Last Year's Accomplishments
The FFY09 objective of 12.7 was met. Iowa's provisional 2009 Vital Statistics data indicate that the suicide rate for youths aged 15-19 was 9.7 per 100,000. This rate is still provisional as it based on the 2008 population data for youths aged 15 through 19.

INFRASTRUCTURE BUILDING SERVICES: Between May 2008 and May 2009, IDPH funded five community projects to screen youth in schools for mental health problems and referral and follow-up services. Thirty-two schools are using the Columbia TeenScreen program, which has screened over 1,800 youth.

The Child Death Review Team examines records of children whose cause of death has been listed as a suicide. Deaths due to suicide or medical conditions may be prevented through timely and appropriate interventions to combat depression, bullying, and disease. The most frequent means of ending a life resulted in the use of firearms. According to the Centers for Disease Control and Prevention, over the last few years youth suicides have decreased nationally with the use of firearms, whereas there has been an increase in hangings. In Iowa, this trend was followed until 2006 before it was reversed.

The Child Death Review Team recommended parent education related to monitoring their child's behavior so that they can tell if the child becomes withdrawn, sullen or exhibits radical changes in behavior. Conferring with school officials to assess modified behavior and address it in a nonthreatening, compassionate manner is reinforced.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Parents should seek early treatment for children with behavior problems, possible mental disorders and substance abuse problems.			X	
2. Limit young people’s access to lethal means of suicide, particularly firearms.				X
3. Encourage health care plans to cover mental health and substance abuse on the level physical illnesses are covered.				X
4. Schools should implement mental health screening programs for children. Teachers should be educated about suicide risk factors and resources to which they may refer children for assistance.				X

5. Children who have attempted suicide or displayed other warning signs should receive aggressive treatment services.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Between May 2009 and May 2010, IDPH funded seven community projects to screen youth in schools for mental health problems, referral and follow-up services. Approximately 45 schools are using the Columbia TeenScreen program and over 1,800 youth have been screened.

This is the last year of the Youth Suicide Prevention grant funded by SAMHSA. IDPH has requested a 12 month no cost extension. Initiatives for this period include:

• Continue funding TeenScreen programs across Iowa
• Promote TeenScreen Primary Care with pediatricians and primary care providers
• Promote the Suicide Prevention Lifeline
• Fund web-based gatekeeper training for college faculty and students
• Provide "Assessing and Managing Suicide Risk" training to mental health clinicians
• Provide training on the American Foundation for Suicide Prevention's (AFSP) "More Than Sad" DVD series for high school teachers and students
• Provide training for college counseling staff and faculty on the AFSP's, "Truth about Suicide" DVD for college students
• Provide funding to local suicide prevention coalitions to expand capacity and provide training
• Provide web-based training to healthcare providers through the American Association of Suicidology's "Recognizing and responding to Suicide Risk: Essential Skills in Primary Care" program
• Develop the role of suicide survivors in suicide prevention

c. Plan for the Coming Year

This is the last year of the Youth Suicide Prevention grant funded by SAMHSA. IDPH will continue to seek funding opportunities for work in youth suicide prevention. Other upcoming youth suicide prevention initiatives include:

• Distribution of the "More Than Sad" DVD training series by the American Foundation for Suicide Prevention to every TeenScreen program and AEA in the state. One DVD is designed specifically for high school students in 9th-12th grade and the companion DVD is for high school teachers and staff
• Promotion of the TeenScreen Primary Care program and screening instrument to pediatric and primary care clinics
• Distribution and promote the "Primary Care Toolkit for suicide prevention" to primary care providers, especially in rural areas. The Toolkit was developed by WICHE and the Suicide Prevention Resource Center
• Promotion of the "Recognizing and Responding to Suicide Risk -- Primary Care" webinar (provided by the American Asso of Suicidology) to healthcare providers
• Train 300 mental health clinicians through the "Assessing and Managing Suicide Risk" course
• Promotion of the Suicide Prevention Lifeline (800-273-TALK) in TeenScreen program service areas

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	96	96	96	97	96
Annual Indicator	94.7	94.0	94.2	95.0	93.7
Numerator	463	453	468	420	384
Denominator	489	482	497	442	410
Data Source				Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97	97	97	97	97

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics provisional data.

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

a. Last Year's Accomplishments
The FFY09 performance objective of 96 per 1,000 was met. Iowa's 2009 Vital Statistics data indicates 93.7 percent of very low birth weight infants were delivered at facilities for high risk deliveries and neonates. The current performance in this measure decreased slightly since last year. The rate however has remained stable since 2005. Each year over 93 percent of the VLBW infants are delivered at a facility with the capacity to care for them.

INFRASTRUCTURE BUILDING SERVICES: IDPH, the Statewide Perinatal Care Program and the Department of Human Services medical director meet on a quarterly basis to discuss quality improvement strategies for premature and low birth weight babies on Medicaid.

ENABLING SERVICES: The Statewide Perinatal Care Team continues its current activities with Iowa birthing hospitals. They visited four hospitals that stopped their delivery service to train emergency room staff in assessment and triage of a woman in labor prior to transport emergency delivery and newborn resuscitation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the number of Level II Regional Neonatal Centers.				X
2. Increase access to a higher level of care for the very low birth		X		

weight infants.				
3. Publish the Iowa Perinatal Newsletter on a quarterly basis.			X	
4. Strategize with key officials on quality improvement for premature and low birth weight babies on Medicaid.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Statewide Perinatal Care Team will continue to provide ongoing education about the importance of transferring women to appropriate facilities for birth when they are stable enough for transport. One third of the births at Iowa's Level I community hospitals occurred in the winter months when travel may have been a concern.

INFRASTRUCTURE BUILDING: The Perinatal Team will continue to travel to birthing hospitals each year. The number of hospitals in Iowa that provide a birthing service continues to decline. During their site visits, the team will discuss the increased importance of the regionalized system of care in light of decreased total number of hospitals that provide a birthing service. This will result in less hospital visits next year as one Des Moines hospital went from a level II to a level I and one hospital stopped doing deliveries all together.

In May of 2010 one center, Genesis Medical Center, went from a level II regional center to a level ll regional neonatal center. This will increase the level of neonatal service that is available in southeastern Iowa. There were also two new hospitals built in West Des Moines that both plan to join the regionalized system of perinatal care and apply for level I status.

c. Plan for the Coming Year

IDPH will continue to monitor the access to high risk care for both pregnant women and their infants as community hospitals in rural parts of the state struggle to maintain obstetrical, surgical and anesthesia service capable of round the clock coverage needed to continue their birthing services. Statewide Perinatal program will continue hospital site visits and individual education and quality improvement initiatives. Staff will evaluate and consider any needed updates to the Guideline to Perinatal Care 8th edition published in 2008.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.6	88.7	87	80	76
Annual Indicator	87.2	86.4	77.7	75.9	74.3
Numerator	34244	35047	31740	30513	29469
Denominator	39255	40564	40835	40221	39662
Data Source				Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	77	78	79	80	81

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics data.

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Iowa implemented a revised birth certificate during this reporting period. The questions about entry into prenatal care was changed. Data staff are investigating the accuracy of the reporting. Data were obtained from 2007 Vital Statistics data.

a. Last Year's Accomplishments
The FFY09 performance objective of 76 per 1,000 was not met. Iowa's 2009 Vital Statistics data indicates 75 percent of infants were born to women receiving prenatal care in the first trimester.

INFRASTRUCTURE BUILDING SERVICES: Vital Records/Vital Statistics, the Women's Health Information System and the surveys of women who did not receive early care were used by local agencies to determine the population in need of specific efforts. IDPH staff support collaboration between and among state and local agencies. Integration of MH services with WIC, CH programs, FP services and DHS programs continues. IDPH staff support and monitor local contract agencies' vulnerable population action plans and advocate for improved access to early prenatal care for undocumented (immigrant) women. All local contract agencies are implementing action plans for early prenatal care targeting vulnerable populations in their communities.

ENABLING SERVICES: Local MH contract agencies provide presumptive eligibility to pregnant women. There are 14 local contract agencies committed to increasing the number of women who receive early entry prenatal care. Activities include: a public awareness campaign; outreach presentations to churches, schools and community centers; and flyer distribution to pregnant women. WIC and MCH staff provide follow-up encouraging education on early prenatal care.

The number of agencies who offer free pregnancy tests has doubled and is expected to increase early identification of adolescent pregnancies. School nurses are informed which agencies provide free pregnancy testing. Local MH agencies can now bill for completing the application for presumptive Medicaid eligibility determination.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase outreach presentations to churches, schools, and community centers.		X		
2. Promote communication and collaboration among local maternal health agencies and other local agencies.				X
3. Integrate maternal health services with WIC, child health programs, family planning services, and DHS programs.				X
4. Target vulnerable populations.				X

5. Advocate for improved access for undocumented (immigrant) women.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Fourteen local contact agencies plan to continue ongoing surveys of women who entered prenatal care late. They plan to use the data to continue to identify local barriers for accessing prenatal care. The survey this year indicates that African American and Hispanic enter into care later than Whites. Surveys also show women delayed care due to denial of the pregnancy, were afraid to tell their parents, had no insurance, just moved to Iowa so did not know where to go, and had transportation issues.

ENABLING SERVICES: Three agencies are planning specific activities for Hispanic women in their communities Surveys have shown there is a need for education on the importance of prenatal care in this population.

There is continued collaboration with family planning agencies and other agencies that do pregnancy testing to increase early referrals. Many agencies are doing more outreach to nail salons, hair salons, as well as traditional outreach with school nurses and local health care providers.

c. Plan for the Coming Year

The Bureau of Family Health staff and local maternal and child health contract agencies will increase emphasis on ensuring access to presumptive eligibility determination. The Bureau will also be working to improve a working relationship with Federally Qualified Health Centers to encourage them to provide prenatal care, which would improve access to prenatal care for low income women who are not Medicaid eligible.

D. State Performance Measures

State Performance Measure 1: *Percent of children served by family support programs, whose primary delivery method is a home visit, that are served through evidence-based programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12	55	60	20
Annual Indicator	19.0	22.9	22.9	18.8	18.8
Numerator	11	6815	6815	6634	6634
Denominator	58	29756	29756	35254	35254
Data Source				family support programs scan	family support programs scan
Is the Data Provisional or Final?				Provisional	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	22	24	25	27	

Notes - 2009
2009 Data were obtained from an environmental scan of family support programs funded through the EC system.

Notes - 2008
2008 Data were obtained from an environmental scan of family support programs funded through the EC system

Notes - 2007
Data were obtained from an environmental scan conducted in February of 2007 with family support programs whose primary delivery method is a home visit. The peformance measure data set was change to show the most recent data on family support. The environmental scan will be updated every two years.

a. Last Year's Accomplishments
The FFY09 performance objective of 20 percent was not met. A 2008 environmental scan of family support programs funded by Iowa's Early Care, Health, and Education system and the number of children served indicated 6,634 out of 35,254 children were served by evidence-based programs, which is 19 percent. The decrease in the indicator is likely attributable to an influx of new programs that do not utilize evidence-based approaches. Iowa is working on improving the quality of family support programs through the implementation of Iowa's Family Support Credential.

The Credential process is in the first year and will take a few years to see an increase in the number of programs in quality programs.

INFRASTRUCTURE BUILDING SERVICES Through the Early Childhood Comprehensive Systems Project, Early Childhood Iowa (ECI) Quality Services and Programs (QSP) component group has addressed the quality of family support and parent education and provided tools and technical assistance to local programs. The Family Support Leadership group met twice to provide strategies and advice for family support and parent education. The Family Support Coordinator with the Office of Empowerment serves as the lead staff person for the family support projects workgroups.

Iowa's Family Support Credentialing process continued to gain support at the state and local level. A Family Support Credentialing workgroup that includes sub workgroups oversaw the process along with the Family Support Leadership group. Based on three Family Support Peer Review pilots conducted in 2007, the Family Support Credentialing process was reworked and rolled out in January of 2008. By the end of FFY09, over 50 programs were accepted. Through the Peer Review and Credentialing Process reviewers were selected and trained and a Family Support Technical Assistance Team was trained to begin work with the participating local family support programs.

The Family Support Leadership Group (FSLG) workgroup met regularly to address Standards and Core Competencies and the Outcomes and Credentialing Process workgroup. The workgroups included members beyond the network of the core FSLG. Family organizations were represented on the FSLG.

The University of Iowa National Resource Center for Family Centered Services provided the certification program for family support supervisors.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership for the Title V home visiting need assessment.				X
2. Continue to promote the Iowa Family Support Credential.				X
3. Convene the Family Support Leadership Group.				X
4. Focus efforts on common indicators for all family support programs.				X
5. Promote the Family Support Supervisory Training.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Seventy (70) programs completed the Family Support Credentialing application and were accepted into the credentialing process. Two programs have received the Iowa Family Support Credential. A waiting list of over 20 programs exists due to limited funding.

The University of Iowa also developed core competencies for family support workers and family support supervisors as a critical step in the curriculum development. The Family Support Core Competencies workgroup began the process of reviewing the core competencies and competencies from other states.

The Outcome workgroup developed a core set of indicators for all family support and parent education programs. ECI is developing a comprehensive early childhood professional development system for early care and education, health and family support professionals. A workgroup comprised of representatives from all family support program models convened to develop a systematic approach to professional development for family support. Work is in progress to: 1) outline the professional development needs required by the program model, and 2) outline best practice recommendations for family support workers.

An ad hoc group has been formed from the Family Support Leadership Group to serve as a work team for the Title V home visiting grant. The workgroup has been meeting since May and has provided significant leadership to the BFH for the first grant application and the start of the needs assessment.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The Family Support Leadership workgroups continues to meet and advance strategies. The Peer Review and Credentialing Process will provide technical assistance to local family support programs engaged in the credentialing process. The Family Support Coordinator will continue to work with local providers to improve the program.

The Family Support Leadership group will explore the development of a Parent Leadership group in partnership with the ECI Governance Component group. The Leadership group will address key strategies such as the development of parent leadership and improving effective strategies on receiving and getting input from parents. ECI Governance Component group is researching parent Council/leadership groups in other states and will make recommendations on best

practices to the Family Support Leadership Group and the Early Childhood Iowa Council.

Quality Services and Programs members will continue to advocate for Iowa Family Support Credentialing process funding to reduce the waiting list.

The Family Support Leadership Group will continue to serves in an advisory role for the IDPH home visitation needs assessment and implementation plan.

State Performance Measure 2: *Percent of early care and education businesses who have received a training or service from a child care nurse consultant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1224	1750	35	40
Annual Indicator	1182	1717	29.7	39.6	52.4
Numerator			2280	3045	4028
Denominator			7688	7688	7688
Data Source				NCCIC Iowa profile	NCCIC Iowa profile
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	42	45	50	52	

Notes - 2009
Data from the National Child Care Information Center, State profile for Iowa: Total Number Licensed/Regulated FCCG added to the Number of Licensed/Regulated Child Care Centers

Notes - 2008
2008 Data collected from the National Child Care Information Center, State profile for Iowa: Total Number Licensed/Regulated FCCG added to the Number of Licensed Child Care Centers. The objective changed in 2007 from the number businesses that have received training to a percentage of businesses.

Notes - 2007
Data were obtained from the Healthy Child Care Iowa encounter data and the National Child Care Information and Technical Assistance Center.

a. Last Year's Accomplishments
The FFY09 performance objective of 40 percent was met. The 2009 Child Care Nurse Consultant encounter data shows 52.4 percent of early care and education businesses received a training or service from a child care nurse consultant.

INFRASTRUCTURE BUILDING SERVICES: Healthy Child Care Iowa staff conducted two sessions of the Iowa Training Project for Child Care Nurse Consultants (CCNC), completed a method to collect CCNCs encounter data online, and developed an advocacy document in support of CCNC services.

POPULATION-BASED SERVICES: HCCI staff conducted 3 professional development, distance-learning events for early childhood care and education providers and placed Universal Precautions/Exposure Control Plan training online for early child care and education providers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to serve on the Quality Rating System oversight team.				X
2. Provide technical assistance training to child care nurse consultants.			X	
3. Continue to advocate for sustained child care nurse consultant funding.				X
4. Continue the operations of the HCCI talkline and Web site.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES

In December, 2009 an evaluation of the HCCI system was completed. The evaluation identified two significant concerns. Staffing levels of less than .5 FTE are too low to efficiently provide service and outcome data to demonstrate effectiveness are not currently part of the system. A separate evaluation of the health and safety tools utilized in the QRS is currently in progress with results anticipated in October 2010.
At the same time, The Iowa QRS is undergoing a recalibration process with many changes being made. Community and state agency collaboration to provide resources initially committed to HCCI are eroding. State agencies are proposing significant system level changes which limit the capacity for development of the CCNC system. One of the proposed changes is the removal of the nursing assessment tools, from the QRS process.

c. Plan for the Coming Year
CCNCs will be delivering the medication administration, emergency preparedness, universal precautions and exposure control plans, mandatory child abuse reporter, ChildNet Module - Germs: Yours, Mine and Ours, and injury prevention trainings statewide to child care providers. Five additional information tools will be created for CCNCs to use with child care providers including the topics of swaddling, safe sleep and electrical safety.

State Performance Measure 3: *Percent of Medicaid enrolled children zero to five years who receive developmental evaluations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		7	10	12	3
Annual Indicator	8.2	4.4	4.1	2.3	3.4
Numerator	7004	3842	3624	2142	3770
Denominator	85386	87979	89419	92966	109932
Data Source				CMS 416 report	CMS 416 report

Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	5	8	10	

Notes - 2009
The 2009 data were obtained from the CMS 4.16 Annual EPSDT Participation Report. The previously reported denominators for fiscal year 2005-2008 has changed for this report. The difference related to revisions to the 4.16 data which are more relialbe than from the previous years.

Notes - 2008
The 2008 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

a. Last Year's Accomplishments
The FFY09 performance measure of 3 percent was met. Data from the CMS 4.16 Annual EPSDT Participation Report show that the percent of Medicaid enrolled children ages 0-5 who received developmental evaluations was 3.4 percent. Two main contributing factors continue to be: 1) lack of awareness among primary care providers regarding Medicaid reimbursement and 2) focus on enhanced surveillance more than screening for those practices partnering with 1st Five. 1st Five sites are making concerted efforts to promote developmental screening by offering ASQ trainings to participating medical practices and championing other community service providers who have existing working relationships with medical practices to promote screening. Additionally, 1st Five is engaged with other statewide efforts to support primary care provider networks to promote developmental screenings among their members. In spite of these focused interventions and project evaluation data that suggest progress was made, Medicaid developmental screenings continue to be low for FFY09 data.

INFRASTRUCTURE BUILDING SERVICES
IDPH continued to implement strategies designed to improve services that support healthy mental development with a focus on children ages 0-5. IDPH added two implementation sites that serve four counties. During SFY09, 50 medical practices were engaged in 1st Five identification, referral and follow-up. Participating medical practices report serving patient populations of approximately 53,000 children ages 0-5. The state coordinator position was vacant for most of FY09 and subsequently filled July 1, 2009 with a .5 FTE. Vacancy contributed to less than expected progress.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical assistance to local 1st Five projects.				X
2. Develop a public awareness campaign on the importance of developmental screening and surveillance.				X
3. Collect and evaluate data on screenings, referrals, and follow-up from pilot projects.				X
4. Continue to work with Early Childhood Iowa, Iowa Medical Home initiative, and Iowa's Project LAUNCH Initiative.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

In October 2009, 1st Five received a 10 percent budget cut that limited the ability to fund additional sites. Although a portion of this funding was reinstated, replication for new community planning or implementation sites is not financially feasible. The 1st Five state coordinator serves on several state-level councils that include developmental screening and building partnerships with primary care provider networks as priorities. The coordinator also focuses on providing TA to the 1st Five sites. Identification, referral and follow-up protocols continue to be refined across sites between medical providers and public health providers.

The 1st Five medical consultant, Dr Larew, is the Clinical Associate Professor of Pediatrics at the University of Iowa Children's Hospital and member of the University's Division of General Pediatrics and Adolescent medicine. Dr. Larew provides technical assistance to 1st Five medical practices on practical applications for surveillance and developmental screening, caregiver depression, autism screening, Medicaid billing and coding. Additionally, she serves on the state Medical Home Advisory Council and provides a necessary link between 1st Five and the council.

Iowa was awarded a Project LAUNCH grant in September 2009. The 1st Five initiative is part of the developmental screening component of LAUNCH. The 1st Five coordinator serves on the State Young Child Wellness Council.

c. Plan for the Coming Year

The 1st Five coordinator and medical consultant will continue to work with 1st Five sites on surveillance and screening policies and procedures. The 1st Five coordinator will continue to be involved in Iowa's Project LAUNCH at the state and local level focused on the developmental screening component.

State Performance Measure 4: *Percent of children who needed care from a specialist who received the care without problem.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		87	88	89	90
Annual Indicator	83.7	85.1	85.1	85.1	85.1
Numerator	101929	113046	113046	113046	113000
Denominator	121842	132839	132839	132839	132839
Data Source				2005 Child and Family Household Health Survey	2005 Child and Family
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	91	92	93	94	

Notes - 2009

Although our data source for this SPM (the Iowa Child and Family Household Health Survey) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve families' ease of access to specialty care. We are now engaged in plans to implement the third administration of the Iowa Child and Family Household Health Survey in 2010. If a continuing state priority, new data for this annual performance indicator should be available for the 2010 reporting year.

Notes - 2008
Although our data source for this SPM (the Iowa Child and Family Household Health Survey) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve families' ease of access to specialty care.

We are now engaged in plans to implement the third administration of the Iowa Child and Family Household Health Survey in 2010. If a continuing state priority, new data for this annual performance indicator should be available for the 2010 reporting year.

Notes - 2007
Although our data source for this SPM (the Iowa Child and Family Household Health Survey) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve families' ease of access to specialty care.

a. Last Year's Accomplishments
The FFY09 performance objective of 90 percent was not met based on results of the population-based 2005 Iowa Child and Family Household Health Survey. The indicator value derived from the survey was 85.6 percent. CHSC has set a higher target objective to motivate continuous performance improvement.

INFRASTRUCTURE BUILDING SERVICES:
In FFY09, CHSC staff served on the advisory group for Iowa's safety net provider collaborative network, one goal of which is to improve access to specialty services for safety net users.
CHSC participated in the Off to a Good Start Coalition meeting. The meeting focused on the Early Childhood Comprehensive Systems goals and the integration of health into the early childhood system.
Under SAMHSA support, CHSC and the Iowa Department of Human Services collaborated with other community agencies to continue developing a System of Care to improve access to and quality of mental health services for children and youth with severe emotional disorder.

DIRECT AND ENABLING SERVICES:
The CHSC telemedicine behavioral consultation program continued to provide telemedicine and telepsychiatry consultations and telemedicine nutrition consultations to children from geographically remote regions of Iowa who are without access to specialty care.
CHSC's Early Hearing Detection and Intervention project used family participation staff to help families adapt to and understand the special needs and services newly associated with their child's hearing loss.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC co-leads a SAMHSA-supported System of Care project to improve access to quality mental health specialty services for children with severe emotional disorders.				X

2. CHSC parent consultants partner with the Center for Disabilities and Development to teach parents of children with Autism Spectrum Disorder, applied behavioral treatment, using webcams connecting families with behavior specialists in Iowa City.		X		
3. CHSC leads an MCHB-supported Early Hearing Detection and Intervention project to improve access to specialty hearing services for children identified with or as at-risk for hearing problems.				X
4. CHSC's Health & Disease Management unit provides assistance accessing community-based and medical center based specialty services for Medicaid waiver enrollees.		X		
5. CHSC continues telehealth technology and consultation services to meet gaps in access to pediatric medical and behavioral health services.	X			
6. CHSC leads a Family to Family Health Information Center grant that will enhance family knowledge of health care providers and related services and effective communication with providers.				X
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES:

CHSC Co-leads SAMHSA System of Care project to improve access to quality mental health specialty services for children with severe emotional disorder.

CHSC implements Iowa EHDI project to improve access to specialty hearing services.
CHSC administers F2F HIC, which empowers families to more effectively find and participate in their children's
specialty services, and promotes families' knowledge of resources.

CHSC Director delivered the plenary at the 2010 Off to a Good Start Symposium, that advocated incorporating assessment of social determinants of health in any provider care plans for children needing specialty services.

DIRECT AND ENABLING SERVICES:

CHSC's Health & Disease Management unit provides assistance accessing community-based and medical center-based specialty services for Medicaid waiver enrollees.

CHSC uses telemedicine technology and consultation services to meet gaps in access to pediatric behavioral health and nutrition services.

CHSC parent consultants are teaching parents of children with autism spectrum disorder to use Applied Behavior Analysis.

CHSC is developing standards for care coordinators to assure appropriate referrals and communication with specialists.

CHSC Director is a member of the Iowa Autism Council and acts in an advisory capacity to the state in developing and implementing a comprehensive, coordinated system to provide

appropriate diagnostic, intervention and support services for children and adults with ASD.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES

CHSC Pediatric Clinical Consultant will continue to offer advice to Iowa safety net providers to improve access to needed specialty care.

CHSC will continue to co-lead a SAMHSA-supported System of Care project to improve access to quality mental health specialty services for children with severe emotional disorder.

CHSC will continue to lead an MCHB-supported Early Hearing Detection and Intervention project to improve access to specialty hearing services for children identified with or at-risk for hearing problems, with a special emphasis on Latino families.

CHSC will continue to study the social determinants of health and their influence on a child's needs for subspecialty services.

DIRECT AND ENABLING SERVICES

CHSC will implement standards for care coordinators to assure appropriate referrals and communication with specialists.

CHSC will continue telemedicine services for selected condition (e.g. nutrition services, psychiatry/psychology, ABR techniques to parents of children with ASD).

CHSC care coordinators will assure that resources re subspecialty services are shared with families in an effective, efficient manner that is easy to use for families.

State Performance Measure 5: *Percent of children 0-3 years served by Early ACCESS (IDEA, Part C).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		2.4	2.8	2.9	3
Annual Indicator	2.3	2.7	2.7	3.0	3.1
Numerator	2581	2932	3185	3576	3772
Denominator	110650	108593	116411	118296	123587
Data Source				IDEA, Part C Early ACCESS IMS	IDEA, Part C Early ACCESS IMS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.1	3.2	3.3	3.4	

Notes - 2009
Data were obtained from the IDEA, Part C -Early ACCESS Information Management Systems data. Although Iowa currently meets the OSEP recommendations for percentage of the 0-3

populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

Notes - 2008
2008 Data were obtained from the IDEA, Part C -Early ACCESS Information Management Systems data. Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

Notes - 2007
Data were obtained from the IDEA, Part C - Early ACCESS Information Management Systems data.

Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

a. Last Year's Accomplishments
The FFY09 performance objective of 3 percent was met. The FFY09 indicator value was 3.1 percent according to data from the Early ACCESS (IDEA, Part C) database. Although Iowa currently meets the OSEP recommendations for percentage of the 0 to 3 population enrolled in Early ACCESS (IDEA- Part C) (2.3 percent), there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have set progressively higher annual performance target objectives.

INFRASTRUCTURE BUILDING SERVICES
In FFY09, CHSC and IDPH continued collaboration with Iowa's Part C Program to improve access and services to children who have a condition or disability that is known to have a high probability of later delays if early intervention services were not provided. Both CHSC and IDPH identified specific populations of children for whom they provide selected Early ACCESS services. Target populations were identified based on the child health service providers' scope of practice. IDPH received state Early Childhood Iowa professional development funds from Department of Management. With the funds received, IDPH contracted with Enhancing Developmentally Oriented Primary Care out of Illinois and partnered with 1st Five to provide training to a variety of agencies across Iowa that serve children and families on the ASQ and ASQ:SE Developmental Screening tool. Training on the ASQ and ASQ:SE will assist in increasing quality referrals to Part C. Approximately 30 individuals became ASQ and ASQ:SE trainers- those individuals will hold trainings throughout 2010 on the screening tool. IDPH also sponsored training on working with Drug Exposed Children to Part C service coordinators and providers across Iowa. IDPH staff assisted in the development, alpha and beta testing of the electronic Individualized Family Service Plan (IFSP).

DIRECT AND ENABLING SERVICES
Twenty-four local CH agencies provided service coordination and developmental evaluation and assessment for the target population of lead poisoned children with a venous blood lead level of 21 ug/dl or greater. Lead Program case managers worked with local maternal and child health agencies to make referrals for Early ACCESS developmental evaluation and assessment. CHSC provides Part C service coordination at 11 regional centers to three primary populations: children born prematurely, medically complex and drug-exposed. CHSC Clinical Program health providers were a referral source and provided health information on health outcomes to children on IFSPs. CHSC provided Part C nutrition services statewide by connecting families with one of three dieticians using polycom technology.

Early ACCESS continued to contract with CHSC's Iowa Medical Home Initiative to improve the performance of primary care physicians regarding early identification and referrals and promote developmental screening and early intervention services by primary care practices. The Regional Autism Services Program (RASP), based at CHSC and funded by the Department of Education, assures that regional autism teams train local staff to appropriately identify children with autism spectrum disorders.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide IDEA Part C service coordination at all CHSC regional centers for children who are medically complex; drug-exposed; or born prematurely.		X		
2. Expand CHSC Part C service coordination and nutrition consultation for children in Part C with use of ARRA funds.				X
3. Provide nutrition consultation services statewide for children enrolled in IDEA Part C.	X			
4. Partner with IDEA Part C and IDPH 1st Five to improve the performance of primary care providers regarding early childhood developmental screening and referral for early intervention.				X
5. Expand the Regional Autism Services Program to screen all CHSC clinic patients 18-36 mos. for autism and assure regional autism teams train local staff to appropriately identify children with autism condition.				X
6. Continue the Early Hearing Detection Intervention (EHDI) project to improve the system of early identification and referral for children with hearing problems.				X
7. Deliver statewide training on an evidence-based screening tool to increase the quality of Part C referrals and reduce the gap between those served by Part C and those that are not referred to Part C.				X
8. Implement the use of the electronic IFSP in all regions and across signatory partners to increase efficiency of service provision and data collection.				X
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY10, IDPH and CHSC continued collaboration with Iowa's Part C System to improve access and services to children who have or have a high probability for developmental delay.

Iowa Department of Education (DE) received American Recovery Reinvestment Act (ARRA) funds. Part C grantees, CHSC and IDPH received a portion of the funds. With the funds, CHSC expanded service coordination and hired an additional dietician. Seven Part C grantees contracted with CHSC and two grantees contracted with CH agencies for service coordination.

The Early Hearing Detection Intervention (EHDI) project continued to improve Iowa's EHDI surveillance system and assist in identifying children eligible for Part C. The Regional Autism Services Program (RASP) and ASQ and ASQ:SE trainings continue.

DIRECT AND ENABLING SERVICES:

In FFY10, CHSC and CH contract agencies continue to refer to Part C and provide service

coordination and other services to targeted populations of children. CHSC provides Part C nutrition services statewide by connecting a family to one of four registered dieticians using polycom technology.

Part C continued to contract with CHSC's Iowa Medical Home Initiative.

The EHDI project will focus on increasing the percentage of children getting follow-up hearing services and educating families and professionals about the importance of screening and diagnosis.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES:

IDPH plans to develop online DAYC and Lead Exposure training courses. These courses will serve as a refresher for individuals administering the DAYC and for Title V Service Coordinators who serve lead poisoned children. IDPH plans to partner with AEA regions and CHSC in delivering a training on Writing Measurable IFSP Outcomes. IDPH plans to make revisions, as needed, and adopt the AEA Part C Procedure Manual, the manual has been instrumental in standardizing practice across the state. Beginning July 1, 2010 all Early ACCESS IFSPs will developed and stored in the online web application; IDPH will provide training and technical assistance as needed to Title V Service Coordinators on the web IFSP. IDPH will work with Early ACCESS state staff on increasing Early ACCESS' ability to identify eligible children, this will be completed by continuing to spread the use of the ASQ and ASQ:SE screening tools across different agencies by providing either training and/or tools, as funds are available. Lastly, guidance regarding identification of homeless children will be developed so that Early ACCESS increases the number of homeless infants and toddlers in Iowa.

State Performance Measure 6: *Percent of Iowa counties that have at least one participating targeted community in the CDC nutrition and physical activity obesity prevention project.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15	18	24	38
Annual Indicator	12.1	18.2	12.1	36.4	38.4
Numerator	12	18	12	36	38
Denominator	99	99	99	99	99
Data Source				Iowans Fit for Life	Iowans Fit for Life
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	45	48	50	

Notes - 2009
2009 Data were obtained from the IDPH – Iowans Fit for Life Project.

Notes - 2008
2008 Data were obtained from the IDPH – Iowans Fit for Life Project.

Notes - 2007
Data were obtained from the IDPH - Fit for Life Project.

a. Last Year's Accomplishments
The 2009 performance objective of 38 percent was met. Data show that 38.4 percent of Iowa counties have at least one participating targeted community in the nutrition and physical activity obesity prevention project. Iowa's Healthy Community Grant Initiative (community wellness grant) is funding nutrition and physical activity projects in 32 counties and a collaborative project with the Iowa Association of Regional Councils (Councils of Government) is funding projects in six areas.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support Iowans Fit for Life stakeholder group and workgroups.				X
2. Provide technical assistance to local targeted communities working on nutrition and physical activity.			X	X
3. Promote nutrition and physical activity trainings and events to local MCH staff.				
4. Increase communication and collaboration between the BFH programs and Bureau of Nutrition and Health Promotion through IDPH CHAT meetings and State Interagency School Health Team.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Iowans Fit for Life Partnership continues, including the early childhood and the educational settings work group. The early childhood work group completed regional nutrition and physical activity trainings for family support workers. The community wellness grant projects continue in 2010.

c. Plan for the Coming Year
The Early Childhood workgroup of the Iowans Fit for Life Partnership will continue to work on key priorities such as breastfeeding friendly business policies and nutrition and physical education training for family support providers. The Fit for Life staff will also be working with child care businesses on improving policies and practices related to physical activity, nutrition and screen time. The project is funded through ARRA funds and will work in collaboration with DHS, CCR&R, HCCI and Early Childhood Iowa.

State Performance Measure 7: *Percent of Medicaid enrolled children ages 9-35 months receiving a blood lead test.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		60	68	68	69
Annual Indicator	57.5	67.2	61.4	68.5	73.9

Numerator	11768	12251	13281	15532	17884
Denominator	20474	18242	21620	22682	24191
Data Source				STELLAR and Medicaid data match	STELLAR and Medicaid data match
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70	70	

Notes - 2009
Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

Notes - 2008
2008 Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

Notes - 2007
Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

a. Last Year's Accomplishments
The FFY09 performance objective of 69 percent of Medicaid enrolled children receiving a lead test was met. Statewide, 73.9 percent of Medicaid children received a blood lead test.

INFRASTRUCTURE BUILDING SERVICES

BFH worked closely with the Bureau of Lead Poisoning Prevention to monitor statewide data for children receiving blood lead tests. The Bureau of Lead Poisoning Prevention conducted a data match with Medicaid enrolled children in STELLAR (Systemic Tracking of Elevated Lead Levels and Remediation). Data reflecting the percent of children ages 9-35 months receiving a blood lead test (2006 birth cohort) were shared with each local CH agency. The data included testing percentages for both Medicaid and non-Medicaid children within each agency's service area. Local CH agencies continued to monitor and report this performance indicator on the Year End Report. BFH continued to provide training and technical assistance pertaining to blood lead testing.
IDPH and the DE worked together to assist local school districts and public health agencies in implementing the mandatory requirement for blood lead testing prior to school entry. School districts submitted names of kindergarten enrollees who were then matched to the STELLAR database. Children who had not received a blood lead test were referred for testing.

POPULATION-BASED SERVICES

During the 2009 legislative session, required lead screening at kindergarten entry was passed. The Lead Bureau has worked with the Department of Education for the implementation of the required blood lead test. Local CH agencies provided access to blood lead testing by coordinating care through a child's medical home or by providing gap-filling direct care services. The Bureau of Lead Poisoning Prevention's public service announcements and county-specific brochures promoting blood lead testing were shared with local Childhood Lead Poisoning Prevention Programs and public health agencies. Local CH contract agencies continued to provide service coordination under Early ACCESS for children who have venous blood lead levels equal to or greater than 20 µg/dL.

Six local CH contract agencies identified increasing blood lead testing rates as a priority for action

plans. Activities for FFY09 included data collection and analysis; enhanced outreach initiatives; conducting blood lead tests and/or analysis; coordination of care and follow-up; public education efforts; coalition building; and working with local providers to promote blood lead testing.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the state level data for blood lead levels.				X
2. Work with local school districts and public health entities to implement the required lead screening prior to school entry.			X	X
3. Provide technical assistance to local MCH, WIC, and Public Health agencies to promote access to blood lead testing.				X
4. Work with MCH and public health entities to assure that children with elevated blood lead levels receive appropriate follow-up services, including coordination with Early ACCESS (Part C).				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

EPSDT training for local CH agencies emphasizes the importance of blood lead testing for all children according to the Iowa Recommendations for Scheduling Care for Kids Screenings. The Bureaus of Family Health and Lead Poisoning Prevention continue to monitor statewide data for Medicaid enrolled children ages 9-35 months receiving blood lead tests. Local CH contract agencies track and report this performance indicator at year end.

The IDPH and DE work together to implement the mandatory lead testing requirement for children entering school by age six as enacted by the 2008 Iowa General Assembly. This state law has brought heightened awareness to the importance of blood lead testing.
The Centers for Disease Control and Prevention (CDC) is developing a Web-based data system for tracking blood lead test results. Implementation of the data system will improve the quality of the data transmitted to IDPH, including the timeliness of receipt and reporting.

POPULATION-BASED SERVICES:

Local CH contract agencies promote blood lead testing and provide care coordination and follow-up services. Contract agency staff provide service coordination under the Early ACCESS program for children who have venous blood lead levels equal to or greater than 20 µg/dL. Service coordinators complete a Lead Orientation developed by the Bureau of Lead Poisoning Prevention.

c. Plan for the Coming Year

IDPH and the DE will continue to work with local school districts and public health agencies in implementing the mandatory requirement for blood lead testing prior to school entry. This will include increasing public awareness for parents and community members and providing training

for primary care providers. IDPH will continue to follow the data related to lead screenings and make recommendations to policy makers and advocates.

State Performance Measure 8: *Percent of Medicaid enrolled children ages 1-5 years who receive dental services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		38	38	40	47
Annual Indicator	37.0	38.4	42.1	45.2	50.5
Numerator	27646	29413	32808	36642	44760
Denominator	74672	76637	77889	81033	88715
Data Source				CMS 416 report	CMS 416 report
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	49	50	51	52	

Notes - 2009
2009 Data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2008
2008 Data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

a. Last Year's Accomplishments
The FFY09 performance objective of 47 percent was met. 2009 data from the CMS 4.16 report indicate that 50.5 percent of Medicaid enrolled children ages 1-5 years received dental services.

INFRASTRUCTURE BUILDING SERVICES

Last year, I-Smile™ was incorporated into the FFY2009 MCH grant application process. Agencies submitted specific action plans and budgets focusing on the I-Smile strategies of partnerships and planning, local board of health linkage, child health agency staff training, agency oral health protocols, care coordination, education for health care professionals, oral screening and risk assessment, and preventive gap-filling oral health services. In addition to site visits to each agency, Oral Health Bureau (OHB) staff sponsored quarterly meetings for the I-Smile coordinators to ensure a strong program foundation.

The HRSA Targeted Oral Health Service Systems (TOHSS) grant was used to develop oral health promotion in order to assure a dental home for children beginning at age 1, including leveraging funding through Delta Dental of Iowa Foundation (DDIF) for a test market media campaign in eastern Iowa.
The grant was also used to implement an open mouth survey of Head Start/Early Head Start children. The results serve as a baseline for oral health status of low-income children in Iowa. In addition, OHB began collecting oral health status information through the new school screening requirement and enhancements to the Child and Adolescent Reporting System (CAReS).

POPULATION-BASED SERVICES AND ENABLING SERVICES

Health promotion material created through the TOHSS grant was shared with local Title V

agencies, including individualized materials, such as newspaper ads. An I-Smile™ web site was also developed, which includes contact information for I-Smile™ coordinators and information about children's oral health.

Due to the limited number of dentists willing to see children younger than age three or those uninsured, underinsured, or Medicaid-enrolled, most local CH agencies provided oral screenings and preventive services such as fluoride varnish application. Local CH agencies also offered gap-filling oral screenings to assist families in meeting the new school screening requirement.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the I-Smile project at the state and local level.				X
2. Provide technical assistance to local I-Smile coordinators on infrastructure building activities.				X
3. Continue to promote a public awareness campaign on the importance of dental homes.				X
4. Implement physicians trainings on oral health and early childhood in partnership with the Iowa Chapter of the American Academy of Pediatrics.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE-BUILDING SERVICES

OHB staff works closely with Title V child health contractors, providing technical assistance and regular trainings for I-Smile™ Coordinators. OHB staff and the public health dental director maintain regular correspondence with members of the Iowa chapter of the American Academy of Pediatrics to pursue ways to increase the number of children receiving preventive dental services at well-child visits. OHB was also granted an award by Delta Dental of Iowa Foundation to purchase children's books on oral health to distribute to pediatric and primary care offices statewide.

OHB is using several methods for program assessment and determining state needs. An epidemiology intern is determining the rate and ability of families to receive dental care that was recommended as part of required school dental screenings. New CAReS reports are providing oral health status information of children receiving dental screenings from local CH staff.

POPULATION-BASED, ENABLING AND DIRECT SERVICES

Health promotion efforts, also funded through the TOHSS grant, include a request for a public-private partnership with DDIF to expand an I-Smile™ media campaign to the central Iowa television market. The campaign would is airing June and July of 2010. In addition to infrastructure-building activities, Nearly 8,000 fluoride varnish applications and over 9,000 screenings were provided to children younger than 5 in the first two quarter of FFY2010.

c. Plan for the Coming Year
The school dental screening requirement is increasing awareness of the need for early dental care. Collaboration is occurring between I-Smile™ Coordinators, schools, preschools, Head Start centers, child care centers, and health care providers to encourage early and regular check-ups for children.

POPULATION-BASED, ENABLING AND DIRECT SERVICES

I-Smile™ Coordinators will continue to be very involved in local efforts to ensure children receive early and regular care, beginning by the age of 1. The coordinators and other local CH agency staff will assist families through care coordination for dental services. Other activities include working with Head Start, preschools, and child care to coordinate and provide education, screenings, and preventive services such as fluoride varnish applications.

State Performance Measure 9: *Rate (per 1,000 births) of infant deaths due to prematurity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		3.2	3.1	3.1	3.1
Annual Indicator	3.2	3.0	3.0	3.2	2.2
Numerator	127	121	120	128	89
Denominator	39255	40564	40488	40221	39570
Data Source				Vital Statistics	Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	2.9	2.8	2.7	

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics provisional data.

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from provisional 2007 Vital Statistics provisional data.

a. Last Year's Accomplishments
The FFY09 performance objective of 3.1 percent was met. The 2009 Vital Statistic Provisional data show the rate of infant deaths due to prematurity at 2.2 per 1,000 births.

INFRASTRUCTURE BUILDING SERVICES
IDPH staff continued to provide training to local MCH and FP agencies on assessing tobacco use, advising them to quit and referring women to Quitline Iowa. A Maternal Health Taskforce within IDPH and Iowa Medicaid Enterprise (IME) is collaborating efforts to reduce smoking among pregnant Medicaid women. This task force meets quarterly.

Local MH agencies received training on tobacco cessation counseling and on the rising preterm birth rate in Iowa. The training also included information on free nicotine replacement therapy available to Medicaid members in Iowa. The Quitline Iowa developed a specific tobacco cessation program specifically for pregnant and postpartum women.

The winter issue of the Iowa Perinatal Letter was titled The Rising Pre-term Delivery Rate in Iowa -- Three Things We Can Do Now. The newsletter is mailed to all health care providers in Iowa who deliver babies and is also posted on the IDPH Web site at the following site: http://www.idph.state.ia.us/hpcdp/common/pdf/perinatal_newsletters/perinatal_jan_feb_mar_08.pdf . The article was written in response to the increase 2008 rates.

POPULATION-BASED SERVICES

Legislation was passed in the 2008 General Assembly requiring bars and restaurants to ban smoking in their establishments. This should decrease effects of second hand smoke, especially for pregnant women who work in bars or restaurants.

A Mother's Day campaign by the IDPH Tobacco Division distributed a factsheet that provided state-specific data on tobacco use and related harms for women. The factsheet contained state-specific information on (1) current smoking rates for women, (2) smoking-attributable female deaths, (3) number of moms lost to smoking, (4) expenditures to treat women's smoking-caused health problems, as well as other information. The information also included a Mother's Day factsheet with tips for Moms to help keep their kids from smoking.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide trainings to local MCH agencies on smoking cessation.			X	X
2. Continue to promote the partnership with the Division of Tobacco, Planned Parenthood and ACOG.				X
3. Tobacco Bureau has media campaign focused on tobacco cessation for women.			X	X
4. Monitor new data from WIC on tobacco use of Iowa Mothers enrolled in WIC.				X
5. Distribute newly develop tobacco cessation posters and brochures to MH and FP agencies.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

The partnership with IDPH Division of Tobacco Use Prevention and Control, ACOG, Planned Parenthood and local FP agencies continue to be strong. The group collaborates on ideas to reduce tobacco use among women of child bearing age. The Tobacco Division fund created and aired a TV spot aimed at women 18-44 (The Play, first page of 2010 TV Scripts document) as well as a targeted brochure and poster for women's clinics that will be shared with our local MH and FP agencies. The Tobacco Division held a focus group and created a television spot that was created in June 2010 and will air in December 2010.

The Statewide Perinatal Team will continue to reinforce three concepts identified as priorities in Iowa Perinatal Centers: adopting a zero tolerance policy for any elective delivery before 39 weeks based on good ob dating; utilizing progesterone therapy in women who have a history of pre-term birth; and increasing efforts to diminish exposure to cigarette smoke, both primary smoke and

second hand smoke.

In 2010, IDPH started to monitor new data available from the Iowa WIC staff.

c. Plan for the Coming Year
The Maternal Health Taskforce a partnership between DHS and IDPH will continue to meet quarterly. The taskforce will track Medicaid birth outcomes including data on the number of pregnant Medicaid women in Iowa who smoke.

State Performance Measure 10: *Number of professionals trained on the use of appropriate maternal depression screening tools and the available referral resources.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		600	200	1500	750
Annual Indicator					
Numerator	150	150	1440	784	500
Denominator	1	1	1	1	1
Data Source				Maternal Depression trainings	Maternal Depression trainings
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	750	750	750	750	

Notes - 2009
Data were obtained from Maternal Depression trainings that were conducted in 2009. The objective was not met in part because approximately half of the trainers did not submit evaluation data from their trainings. Staff are working with trainers to make sure evaluation data is completed.

Notes - 2008
2008 Data were obtained from Maternal Depression trainings that were conducted in 2008. The objective was not met in part because approximately half of the trainers did not submit evaluation data from their trainings. Staff are working with trainers to make sure evaluation data is completed.

Notes - 2007
Data were obtained from Maternal Depression trainings that were conducted in 2007.

a. Last Year's Accomplishments
The FFY09 performance objective of 750 persons trained was not met. The Maternal Depression Train the Trainer data from 2009 shows 500 persons were trained.

INFRASTRUCTURE BUILDING SERVICES

Funding was secured for the fourth round of Train the Trainer. Twenty-five additional trainers will be certified to provide training at the local level. The Support and Training to Enhance Primary Care for Postpartum Depression (STEP- Postpartum Depression) evaluation is completed, and is

available online to train medical professionals. The program Web site is www.step-ppd.com and it is available to providers free of charge.

An online consultation service provides free mental health consultation with a psychiatrist at the University of Iowa for nurse practitioners, family practice and obstetric providers in the state. The services can be found on our web site www.beyondtheblues.info.

A resource list of mental health providers in all 99 Iowa counties was developed and added to the perinatal depression Web site www.beyondtheblues.info.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to promote the Maternal Depression train the trainer in partnership with the University of Iowa Center for Depression and Clinical Research.				X
2. Provide support for local maternal depression trainings.			X	X
3. Continue to work on the Perinatal Depression Project.				X
4. Collaborate with Early Childhood Iowa, 1st Five, and Iowa Medical Home Initiative.				X
5. Through the Center of Depression and Clinical Research, provide a newsletter on maternal depression.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES

IDPH will distribute over 1,000 pocket guides from the STEP- PPD training to primary care professionals who deliver babies in Iowa and mental health professionals. The content was developed by Michael O'Hara PhD (Psychologist) and Scott Stuart M.D. (Psychiatrist) from the University of Iowa Center for Depression and Clinical Researchers that are nationally recognized experts in this field of study and research. Medication guides were also developed and posted to the web site.

Because lack of insurance can be a barrier to postpartum women receiving treatment for Depression, IDPH met with DHS to explore extending Medicaid coverage for women with postpartum depression until one year after the baby's birth to cover the costs of medication and treatment for depression. The Medicaid director was unable to approve our request due to current financial stress; however, Iowa Medicaid leadership agreed to revisit this proposal in the future.

c. Plan for the Coming Year
IDPH will continue to be involved in the maternal depression train the trainer through the University of Iowa. Project LAUNCH staff will be working with University of Iowa Center for Depression and Clinical Research on increasing the awareness of caregiver depression and providing resources to primary care providers, parents and community members in the LAUNCH demonstration site.

E. Health Status Indicators

Introduction

The nine Health Status Indicators (HSI) provide critical information about the capacity of Iowa's MCH health status for the Title V populations served. Iowa made progress on the HSI in recent years, as indicated on forms 20 and 21. There are several reasons for the improvements seen in the HSI measures.

State agency coordination activities, such as those described in the previous section of this application, had a positive impact on the capacity of IDPH to progress on specific initiatives. For example, the maternal health program, local maternal health agencies and local maternity providers have worked together to increase access to maternity services throughout the state. Ongoing partnerships between IDPH and other state departments also had a positive impact.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.2	6.9	6.8	6.7	6.7
Numerator	2829	2814	2795	2683	2674
Denominator	39255	40564	40835	40221	39662
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data were obtained from 2009 Vital Statistics data.

Notes - 2008

Data were obtained from 2008 Vital Statistics data.

Notes - 2007

Data were obtained from 2007 Vital Statistics data.

Narrative:

Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. In 2005 the percentage was 7.2 and in 2009 the percentage is 6.7. Over the past five years there has been a slight decrease each year in LBW births.

Data on this indicator are reviewed annually to identify trends and areas of concern. Program staff uses the data to identify emerging strategies that can be used to decrease the percentage of LBW infants. Some strategies include tobacco cessation training for local MH contract agencies and partners. The Tobacco cessation training team includes ACOG representatives, Planned

Parenthood, Bureau of Family Health and the Division of Tobacco Control. The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are receiving the appropriate level of care.

Additionally, as noted in Health System Capacity Indicator 5A, access to smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits was made available to Medicaid eligible pregnant women in response to data which reflected a high proportion of women who reported that they smoked during pregnancy. This policy change took effect January 2008. Evaluation of this strategy will be conducted as a component of the Medicaid/Birth Certificate match.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.4	5.3	5.1	4.9	4.9
Numerator	2047	2058	1995	1913	1888
Denominator	37883	39152	39369	38737	38246
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Narrative:
Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. The LBW singleton percent for 2005 was 5.4 and 4.9 for 2009. Over the past five years there has been a slight decrease each year in the singleton LBW births.

Data on this indicator are reviewed annually to identify trends and areas of concern. Program staff uses the data to identify emerging strategies that can be used to decrease the percentage of LBW infants. Some strategies include tobacco cessation training for local MH contract agencies and partners. The Tobacco cessation training team includes ACOG representatives, Planned Parenthood, Bureau of Family Health and the Division of Tobacco Control. The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are

receiving the appropriate level of care.

Additionally, as noted in Health System Capacity Indicator 5A, access to smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits was made available to Medicaid eligible pregnant women in response to data which reflected a high proportion of women who reported that they smoked during pregnancy. This policy change took effect January 2008. Evaluation of this strategy will be conducted as a component of the Medicaid/Birth Certificate match.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.4	1.3	1.3	1.2	1.1
Numerator	543	509	544	501	446
Denominator	39255	40564	40835	40221	39662
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Narrative:
Very low birth weight percentage in Iowa has remained virtually the same with minor decreases and increases over the past five years. The VLBW went from 1.4 percent in 2005 to 1.1 percent in 2009. See #1 A and B for strategies that Iowa is implementing

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.0	1.0	0.9	0.9	0.8
Numerator	377	374	357	346	310
Denominator	37883	39152	39369	38737	38246
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Narrative:
Very low birth weight percentage in Iowa has remained virtually the same with minor decreases and increases over the past five years. The singleton VLBW was 1.0 percent in 2005 to .8 percent in 2008. See #1 A and B for strategies that Iowa is implementing.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.3	14.6	7.5	8.7	5.8
Numerator	40	85	44	51	34
Denominator	547627	581387	583316	586749	589813
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
The data were obtained from 2007 Vital Statistics data.

Narrative:
Unintentional injuries are the result of about half of all the deaths to Iowa residents ages 1-14. The death rate due to unintentional injuries among children ages 14 and young is 5.8 per 100,000. Since 2005, annual rates demonstrated noticeable fluctuations, but no clear trends. In 2004 the rate was 11.1, 2005- 7.3, 2006 -14.6, 2007- 7.5 and 2008- 5.7.

To prevent mortality in these age groups, state and local partners are working with SAFE Kids coalition and many other injury prevention organizations. One strategy example for reducing mortality includes partnering with the Iowa Health System in presenting "Think First! Injury Prevention Program." The program informs youth during school programs about the profound

consequences of not wearing seatbelts and encourages safe behaviors.

The Iowa Department of Public Health - Healthy Child Care Iowa Campaign has been working with child care businesses for the past ten years on improving the healthy and safety of early learning environments for children.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.4	2.1	4.6	2.7	3.1
Numerator	24	12	25	16	18
Denominator	547627	581387	543571	586749	589813
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Narrative:
Unintentional injuries are the result of about half of all the deaths to Iowa residents ages 1-14. The death rate from unintentional injuries due to motor vehicle crashes among youth ages 15 through 24 was 3.1 per 100,000 2008.

To prevent mortality in these age groups, state and local partners are working with SAFE Kids coalition and many other injury prevention organizations. One strategy example for reducing mortality includes partnering with the Iowa Health System in presenting "Think First! Injury Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	35.8	23.8	26.5	18.7	15.1
Numerator	155	105	115	81	67
Denominator	433548	440689	433507	432262	444697
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Narrative:
Unintentional injuries are the result of about half of all the deaths to Iowa residents ages 1-14. The death rate from unintentional injuries due to motor vehicle crashes among youth ages 15 through 24 is 15.1 per 100,000 in per 100,000 in 2008. In 2005, the state saw a drastic increase to 35.8 per 100,000.

To prevent mortality in these age groups, state and local partners are working with SAFE Kids coalition and many other injury prevention organizations. One strategy example for reducing mortality includes partnering with the Iowa Health System in presenting "Think First! Injury Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10,217.2	10,061.1	9,722.9	7,353.9	7,936.8
Numerator	55952	58494	56715	43149	46812
Denominator	547627	581387	583316	586749	589813
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Iowa Health Association data.

Notes - 2008
Data were obtained from Iowa Health Association data.

Notes - 2007
Data were obtained from Iowa Health Association data.

Narrative:
Surveillance of unintentional injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Unintentional injuries are often a contributing factor in temporary or permanent disability or poor health. Iowa currently collects the data from the Department of Transportation database. Since 2005 there has been a slight decrease in the nonfatal injuries to children ages 14 and younger. in 2008 the rate is 7,936 per 100,000 for children ages 14 and young for nonfatal injuries.

The Iowa Department of Public Health works with the Iowa Safe Kids Coalition to promote public awareness of healthy behaviors for parents and children. Some examples include farm safety, pool safety, bike safety.

The Iowa Department of Public Health - Healthy Child Care Iowa Campaign has been working with child care businesses for the past ten years on improving the healthy and safety of early learning environments for children.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	240.5	221.7	217.9	303.7	294.2
Numerator	1317	1289	1271	1782	1735
Denominator	547627	581307	583316	586749	589813
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Iowa Health Association data.

Notes - 2008
Data were obtained from Iowa Health Association data.

Notes - 2007
Data were obtained from Iowa Health Association data.

Narrative:
Unintentional injuries are the result of about half of all the deaths to Iowa residents ages 1-14. The death rate due to unintentional injuries due to motor vehicle crashes among children ages 14 and young is 294.2 per 100,000. Over the past five years the rate has fluctuated giving no real trend data analysis.

To prevent mortality in these age groups, state and local partners are working with SAFE Kids coalition and many other injury prevention organizations. One strategy example for reducing mortality includes partnering with the Iowa Health System in presenting "Think First! Injury

Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1,063.3	1,034.1	1,104.9	1,237.2	1,237.7
Numerator	4610	4557	4790	5348	5504
Denominator	433548	440689	433507	432262	444697
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from 2009 Iowa Health Association data.

Notes - 2008
Data were obtained from Iowa Health Association data.

Notes - 2007
Data were obtained from Iowa Health Association data.

Narrative:
Surveillance of unintentional injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Unintentional injuries are often a contributing factor in temporary or permanent disability or poor health. Iowa currently collects the data from the Department of Transportation database. Since 2005 the rate has slightly increase over the years. The rate for 2009 is 1,237.7/100,000 for children ages 15 through 24.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	20.9	21.3	22.1	24.3	24.4
Numerator	2132	2259	2349	2582	2597
Denominator	102028	106102	106446	106081	106575
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2008
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2007
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Narrative:
Chlamydia can impact a woman's future fertility and has few recognizable symptoms. The Iowa Department of Public Health's Sexually Transmitted Disease Program is continuing its successful efforts to accomplish state and federal goals. In a rural state like Iowa, the STD program must partner with other groups, agencies, and organizations for the delivery of information and services. The combination of local health departments and a network of local medical providers are the system that controls these diseases.

In the state of Iowa, Chlamydia is reportable to the Iowa Department of Public Health. By Iowa Code, both the physician who ordered the test and the laboratory who processes the specimen are both to report names and other patient demographics. This information is protected by law and cannot be released to anyone other than individuals (disease prevention specialists and county public health communicable disease investigators) who perform partner notification and partner referral. In Iowa, by law, a minor can be tested and treated for a sexually transmitted disease without parental consent.

The rate of reported Chlamydia cases for women ages 15 through 19 has increased slightly over the past five years. The rate in 2009 is 24.4 per 1,000. A screening pilot project for testing women coming in for pregnancy testing and offered a chlamydia/gonorrhea continues to be successful through a partnership with IDPH and two local women's health centers in Waterloo and Davenport.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.3	10.2	8.0	8.9	8.6
Numerator	3131	4933	3817	4187	4069
Denominator	498792	481366	476502	473044	471168
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2008
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2007

Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Narrative:
Chlamydia can impact a woman's future fertility and has few recognizable symptoms. The Iowa Department of Public Health's Sexually Transmitted Disease Program is continuing its successful efforts to accomplish state and federal goals. In a rural state like Iowa, the STD program must partner with other groups, agencies, and organizations for the delivery of information and services. The combination of local health departments and a network of local medical providers are the system that controls these diseases.

In the state of Iowa, Chlamydia is reportable to the Iowa Department of Public Health. By Iowa Code, both the physician who ordered the test and the laboratory who processes the specimen are both to report names and other patient demographics. This information is protected by law and cannot be released to anyone other than individuals (disease prevention specialists and county public health communicable disease investigators) who perform partner notification and partner referral. In Iowa, by law, a minor can be tested and treated for a sexually transmitted disease without parental consent.

The rate of reported Chlamydia cases for women ages 20 through 44 increased from 6.3/1,000 in 2005 to to 8.6/1,000 in 2009. A screening pilot project for testing women coming in for pregnancy testing and offered a chlamydia/gonorrhea continues to be successful through a partnership with IDPH and two local women's health centers in Waterloo and Davenport.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	40742	36744	1580	246	1012	37	1123	0
Children 1 through 4	163255	144871	7978	1450	3579	123	5254	0
Children 5 through 9	193469	173104	8718	1656	4090	163	5738	0
Children 10 through 14	192347	175180	7788	1021	3400	126	4832	0
Children 15 through 19	217380	199824	8746	1133	3654	110	3913	0
Children 20 through 24	227317	209490	8476	1149	5031	137	3034	0
Children 0 through 24	1034510	939213	43286	6655	20766	696	23894	0

Notes - 2011

Narrative:
Ninety-four percent of the population is white; however, racial and cultural diversity continues to increase at a gradual, yet steady rate. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000, and continued to increase to 4.2 percent in the 2008. Birth data also indicate an increase in Hispanic

population. Approximately 240,041 children are five or younger and make up about 8.0 percent of the total population. Of the children between the ages of zero and five, 8.9 percent are children of Hispanic origin and there are an estimated 8.9 percent of children who have a special health care need.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	37004	3738	0
Children 1 through 4	147625	15630	0
Children 5 through 9	177198	16271	0
Children 10 through 14	179158	13189	0
Children 15 through 19	205418	11962	0
Children 20 through 24	216554	10763	0
Children 0 through 24	962957	71553	0

Notes - 2011

Narrative:
Ninety-four percent of the population is white; however, racial and cultural diversity continues to increase at a gradual, yet steady rate. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000, and continued to increase to 4.2 percent in the 2008 estimate. Birth data also indicate an increase in Hispanic population. Approximately 240,041 children are five or younger and make up about 8.0 percent of the total population. Of the children between the ages of zero and five, 8.9 percent are children of Hispanic origin and there are an estimated 8.9 percent of children who have a special health care need.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	30	19	4	1	0	0	1	5
Women 15 through 17	945	686	113	10	5	3	20	108
Women 18 through 19	2473	1944	231	31	14	6	45	202
Women 20 through 34	32012	28034	1307	148	722	49	263	1489
Women 35 or older	4202	3602	142	13	194	5	22	224
Women of all ages	39662	34285	1797	203	935	63	351	2028

Notes - 2011

Narrative:
In 2009 data, 86 percent of the live births were born to White mothers, eight percent of Hispanic, five percent to Black mothers and two percent to Asian mothers. In 2008, live births to Hispanic women made up 8.2 percent of all births.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	23	7	0
Women 15 through 17	777	168	0
Women 18 through 19	2156	316	1
Women 20 through 34	29630	2379	3
Women 35 or older	3868	332	2
Women of all ages	36454	3202	6

Notes - 2011

Narrative:
In 2009 data, 86 percent of the live births were born to White mothers, eight percent of Hispanic, five percent to Black mothers and two percent to Asian mothers. In 2008, live births to Hispanic women made up 8.2 percent of all births.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	180	152	24	0	3	0	0	1
Children 1 through 4	47	43	3	0	1	0	0	0
Children 5 through 9	21	16	5	0	0	0	0	0
Children 10 through 14	31	26	3	0	2	0	0	0
Children 15 through 19	90	80	6	0	1	0	0	3
Children 20 through 24	139	128	8	0	2	0	0	1
Children 0 through 24	508	445	49	0	9	0	0	5

Notes - 2011

Narrative:
The death certificate data for children by age group by race is readily available from Vital Statistics as is death certificates data fro children by age group by ethnicity. These data are useful as a tool in public health planning and implementation efforts.

In 2009, there were 500 deaths to childen ages 0-24 with 176 of deaths to infants. White children comprise 88 percent of the deaths to children and Black children comprise 9 percent of the deaths to children. Black infants comprise 13 percent of the deaths to infants.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	159	21	0
Children 1 through 4	38	9	0
Children 5 through 9	18	3	0
Children 10 through 14	29	2	0
Children 15 through 19	86	4	0
Children 20 through 24	132	7	0
Children 0 through 24	462	46	0

Notes - 2011

Narrative:
The death certificate data for children by age group by race is readily available from Vital Statistics as is death certificates data fro children by age group by ethnicity. These data are useful as a tool in public health planning and implementation efforts.

Hispanic children comprise ten percent of the deaths to children. Hispanic infants comprise 14 percent of the deaths to infants. The data show an increase in deaths to Hispanic children from 2008 to 2009.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	807193	729723	34810	5506	15735	559	20860	0	2009
Percent in	29.3	26.6	73.9	78.7	4.7	0.0	60.0	0.0	2006

household headed by single parent									
Percent in TANF (Grant) families	100.0	40.0	15.8	0.9	0.6	0.0	0.0	33.5	2009
Number enrolled in Medicaid	217603	115525	20795	1823	2261	0	0	77199	2009
Number enrolled in SCHIP	19959	11125	472	70	148	20	0	8124	2009
Number living in foster home care	2965	2038	592	85	18	0	0	232	2009
Number enrolled in food stamp program	133902	69087	16004	1244	1097	0	0	46470	2009
Number enrolled in WIC	63448	50587	6633	325	1191	0	4034	678	2009
Rate (per 100,000) of juvenile crime arrests	3017.0	2468.0	10526.0	3508.0	1456.0	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.2	2.7	7.9	6.0	2.4	0.0	0.0	0.0	2009

Notes - 2011
Data obtained from Department of Human Services 2009 data.

Data obtained from 2009 Medicaid enrollment reports.

Data obtained from 2009 Medicaid enrollment reports.

Data obtained from Department of Human Services 2009 data.

Data obtained from 2009 WIC enrollment data.

Data obtained from 2009 Vital Statistics provisional data.

Data obtained from 2009 Vital Statistics provisional data.

Data obtained from Department of Human Services 2009 data.

Narrative:
Data for this year shows an increase in the number enrolled in Medicaid (about 25,924), hawk-i (SCHIP) (around 156), food stamps (18,787) and WIC (around 3,040). The percentage of high school drop-outs continues to slightly increase each year (2.1 in 2007 to 3.2 in 2009).

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	746403	60790	0	2009
Percent in household headed by single parent	27.8	44.3	0.0	2006
Percent in TANF (Grant) families	90.8	9.2	0.0	2009
Number enrolled in Medicaid	217603	22901	0	2009
Number enrolled in SCHIP	19959	1086	0	2009
Number living in foster home care	2965	293	0	2009
Number enrolled in food stamp program	133902	13421	0	2009
Number enrolled in WIC	63448	18157	678	2009
Rate (per 100,000) of juvenile crime arrests	2907.0	3294.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.0	5.3	0.0	2009

Notes - 2011

Narrative:
Data for this year shows an increase in the number enrolled in Medicaid (about 25,924), hawk-i (SCHIP) (around 156), food stamps (18,787) and WIC (around 3,040). The percentage of high school drop-outs continues to slightly increase each year (2.1 in 2007 to 3.2 in 2009).

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	330192
Living in urban areas	242767
Living in rural areas	325650
Living in frontier areas	200167
Total - all children 0 through 19	768584

Notes - 2011
Data represents most recent available census data from 2009.

Narrative:
There about 43 percent of Iowa children living in metro areas in 2007. The breakdowns of geographic residency include: 32 percent urban, 42 percent rural and 26 percent frontier.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	3002555.0
Percent Below: 50% of poverty	3.7
100% of poverty	6.6
200% of poverty	17.5

Notes - 2011
Data represents most recent available census data from 2009.

Narrative:
Data show that children are more likely to live in poverty in Iowa with 4.8 percent of children ages 0 to 19 in households with incomes >50% FPL compared to 3.7 for all of Iowans; 9.9 percent of children ages 0 to 19 in households with incomes below 100% FPL compared to 6.6 percent; 22.3 percent of children ages 0 to 19 in households with incomes below 200% FPL compared to 17.5 percent.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	807193.0
Percent Below: 50% of poverty	4.8
100% of poverty	9.9
200% of poverty	22.3

Notes - 2011
Data represents most recent avaialble census data from 2008.

Narrative:
Data show that children are more likely to live in poverty in Iowa with 4.8 percent of children ages 0 to 19 in households with incomes >50% FPL compared to 3.7 for all of Iowans; 9.9 percent of children ages 0 to 19 in households with incomes below 100% FPL compared to 6.6 percent; 22.3 percent of children ages 0 to 19 in households with incomes below 200% FPL compared to 17.5 percent.

F. Other Program Activities

The MCH Title V program has been extensively involved in providing leadership for changes in the service delivery system for children including but not limited to Early Childhood Iowa Areas, the State Children's Health Insurance Program, Early Hearing Detection and Intervention, Newborn Metabolic Screening, Early ACCESS (IDEA, Part C), and the Iowa Medical Home Initiative. A list of formal and informal organizational relationships is located in the attachment for Organizational Structure section III-C. Contracts and memorandums of agreement are found in the attachment for this section, IV-F.

Family Planning activities are coordinated with the IDPH Family Planning Program and the Family Planning Council of Iowa, the Title X contractor for the state.

The following are other Child Health Specialty Clinic program activities:

1. State and regional staff are involved with planning and operation of Community Empowerment Areas.

2. Staff contribute to course development and teaching for the University of Iowa College of Public Health MCH focus track students and other graduate students.

3. Staff participate in planning and providing experiences for leadership training in Iowa's Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program.

4. CHSC works with the Iowa Department of Human Services to assure quality care for CYSHCN enrolled in Medicaid and SCHIP programs and foster care.

5. Staff participate in planning and field-testing new approaches to delivering physical and behavioral health care services and consultation and nutrition services to community-based sites using telemedicine techniques.

6. CHSC partners with other Iowa public health professionals to co-plan and sponsor the Annual Iowa Governor's Conference on Public Health.

7. Staff participate in a Department of Human Services effort to assure appropriate screenings, evaluations and ongoing medical care for children enrolled in Iowa's foster care system.

8. Staff lead quality improvement efforts within Iowa's statewide system of early hearing detection and intervention for newborns and infants, based on principles obtained by participating in the National Improvement in Child Health Quality (NICHQ) learning collaborative.

9. Staff participate in an MCHB-supported Department of Public Health effort to establish a comprehensive early childhood system.

10. Staff participate in a Department of Human Services effort to assure healthy child mental development by improving early childhood screening practices among primary care providers.

11. Staff participate in IDEA Part C program planning and quality assurance projects and lead efforts to investigate the roles of social determinants of health, as well as home-based toxic exposures on early childhood development.

12. Staff serve in an advisory capacity to the Department of Public Health data integration initiative.

13. Staff serve in an advisory capacity for the Department of Public Health initiative to improve the "provider safety net" (community health centers, rural health clinics, and free medical clinics) for medically underserved Iowans, with a special emphasis on investigating the fit between the medical home model and various safety net providers, especially free medical clinics.

14. Staff serve in an advisory capacity on the Children and Families Congenital and Inherited Disorders Advisory Committee, Iowa Council for Early ACCESS, Iowa Medical Home Advisory Committee, Council for Maternal and Child Health, Iowa Autism Council, and the Prevention and Chronic Care Management Advisory Council and Clinicians.

15. CHSC's Director is a member of the Executive Board, American Academy of Pediatrics, IA Chapter and Co-Chair, American Academy of Pediatrics Planning Committee, Native American Child Health and Canadian Pediatric Society, International Meeting on Indigenous Child Health, March 2011

16. CHSC is represented on the Center for Disabilities and Development "Community Partners Advisory Committee" which seeks to improve community outreach, advocacy, and services to Iowa's citizens with disabilities.

17. Staff partner with the Iowa Department of Public Health and the Univ of Iowa Public Policy Center to prepare, interpret, and disseminate the Iowa Child and Family Household Health Survey, next due in 2010.

18. The CHSC Regional Autism Services Program promotes training health care providers and educators in early detection and intervention strategies for children with autism and other disorders on the autism spectrum. CHSC parent consultants assist parents of children with ASD in learning Applied Behavior Analysis (ABA) techniques via a National Institute of Mental Health grant to the Centers for Disabilities and Development at the University of Iowa.

19. To promote family involvement at all levels of the MCH pyramid, CHSC community-based parent consultants serve on multiple state level advisory groups: Medicaid's Medical Assistance Advisory Committee, Iowa Collaborative Safety Net Provider Network, Early ACCESS (Part C IDEA) Iowa Council on Early Intervention, Governor's Council for Prevention of Disabilities, University of Iowa Center for Disabilities and Development's Community Partnership Advisory Council, the University of Iowa Hospitals and Clinics' Family Advisory Committee, the Maternal and Child Health Advisory Council, and local and county governance boards to guide Community Circle of Care (CCC).

An attachment is included in this section.

G. Technical Assistance

Iowa recognizes the opportunity to build public health capacity for MCH through professional development focused on emerging issues and the changing political landscape including increased recognition of social determinants of health and health equity. Assistance is requested to support a plenary presentation of Iowa's Governor's conference on Public Health to be held on April 5 and 6, 2011 in Ames, Iowa. Additional technical assistance may be requested to support selected components of the Family Household Health Survey.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	6512104	5829198	6529540		6528937	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	5293246	7094149	5057930		5399077	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	5486806	4449314	4527575		4537311	
6. Program Income *(Line6, Form 2)*	1000000	1079449	650000		300000	
7. Subtotal	18292156	18452110	16765045		16765325	
8. Other Federal Funds *(Line10, Form 2)*	4437528	4991800	4948550		6797535	
9. Total *(Line11, Form 2)*	22729684	23443910	21713595		23562860	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1690006	1510250	1551053		1688581	
b. Infants < 1 year old	332114	236537	292566		303163	
c. Children 1 to 22 years old	9331884	9938681	9653433		9403585	
d. Children with	6311739	6156856	4661399		4763458	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	626413	609786	606594		606538	
g. SUBTOTAL	18292156	18452110	16765045		16765325	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	149849		189000		180042	
j. Education	165913		153333		157317	
k. Other						
Autism	0		0		210516	
CCC- SAMHSA	0		0		2090231	
Early ACCESS-CHSC	0		0		1021670	
ECCS -HRSA	0		0		132000	
Family Planning	1208653		1280508		1345021	
Family to Family	0		0		95700	
Newborn Scrn Surv	0		0		115100	
Newborn Scrn-CHSC	0		0		299938	
Project Connect - DV	0		0		200000	
Project LAUNCH	0		0		850000	
CDC EHDI	0		180042		0	
CDC Screening Surv	0		150000		0	
CDC Stillbirth	0		300000		0	
ECCS	105000		105000		0	
Family to Family Inf	0		95700		0	
HRSA EHDI	0		174967		0	
HRSA Family Particip	0		130000		0	
SAMSHA CHSC	0		2090000		0	
Family Participation	128000		0		0	
Medical Home	132000		0		0	
Newborn Hearing	180000		0		0	
SAMHSA Beh. Health	2108113		0		0	
TOHSS Oral Health	160000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	5144406	5122100	4514281		4332382	
II. Enabling Services	4495951	4214826	3746664		3930801	
III. Population-Based Services	2329140	3035052	2058340		1970058	
IV. Infrastructure Building Services	6322659	6080132	6445760		6532084	
V. Federal-State Title V Block Grant Partnership Total	18292156	18452110	16765045		16765325	

A. Expenditures

Form 3, State MCH Funding Profile, shows $5,829,198 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 07 award. Due to a decrease in the state's award for FFY08, carry forward funds were necessary to maintain community-based programs at current levels for maternal health, child health and children with special needs. Administration expenditures were nine percent under budget due to staff vacancies.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY09 in the amount of $18,452,110. Of this amount, $5,829,198 was funded by federal Title V. The state match is reported at $7,094,149. This exceeds both the state match requirement of $4,896,703 and the maintenance of effort requirement of $5,035,775. Federal Title V funds expended for infant and child health primary and preventive care was $1,991,866 or 34 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at $2,155,324 or 37 percent of the federal block grant funds expended for the year. Administration expenditures of $577,691 represent 10 percent of the federal Title V amount.

The attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to infrastructure continue to increase for MCH compared to the proportional of funds directed to direct services. Continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state partnership.

The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with OMB Circular A-133. The most recent report is for the period July 1, 2008 to June 30, 2009. There are no findings in the 2009 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office.

An attachment is included in this section.

B. Budget

The FFY11 Title V appropriation is projected to be $6,528,937 based on the FFY09 award. As itemized in the attachment, this expected allocation is budgeted as follows: $1,357,751 (21%) for maternal health services; $303,163 (5%) for infant health services; $2,070,197 (32%) for child health services; $2,191,288 (34%) for services to children with special health care needs; and $606,538 (9%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. In the attachment, Figure 5 illustrates the budget plan for the FFY11 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is $5,399,077. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989 and exceeds the required match of $4,896,703.

The total budget for the federal-state partnership is projected to be $16,765,325 Attachment, Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of service, as well as population group served.

Direct Services.
The federal-state partnership expenditures for continuation of direct care services are estimated at $4,332,382. This represents approximately 26 percent of the partnership budget. The amount includes 17 percent of the funding for local child health agencies and one percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant projects; and the OB indigent program. CHSC projects a direct care budget of $1,709,411 or approximately 36 percent of the CYSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Enabling Services.
The federal-state partnership expenditures for continuation of enabling services are estimated at $3,930,801 representing 23 percent of the partnership budget. This category includes 33 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT Ill and Handicapped Waiver Services.

Population Based Services.
The federal-state partnership expenditures for continuation of population-based services are estimated at $1,970,058 , which represents 12 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 17 percent of the funding for local child health agencies and 15 percent of local maternal health funds. IDPH projects expenditure of $1,171,230 and CHSC projects a budget of $192,175 or approximately four percent of the CYSHCN budget.

Infrastructure Building Services.
Estimated budget for continuing development of core public health functions and system development are $6,532,084 or 39 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 33 percent of the funding for local child health agencies and 28 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities. CHSC's budget for infrastructure building services is estimated at $768,698 (16 percent of the CYSHCN budget).

Other federal funds directed toward MCH include:
State Systems Development Initiative (HRSA/MCHB)
Early Childhood Comprehensive Systems Grant (HRSA/MCHB)
Title X Family Planning
Early ACCESS (IDEA, Part C)
SAMHSA Integrated Behavioral Health
Targeted Oral Health System Project(HRSA/MCHB)
Iowa Stillbirth Surveillance Project (CDC)
Iowa Newborn Screening Surveillance Project(CDC)
Iowa Family Participation Project (HRSA/MCHB)
Early Hearing Detection and Intervention (CDC and HRSA)
Project LAUNCH (SAMHSA)
Project Connet (DHHS)
An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.